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HIGHLIGHTS



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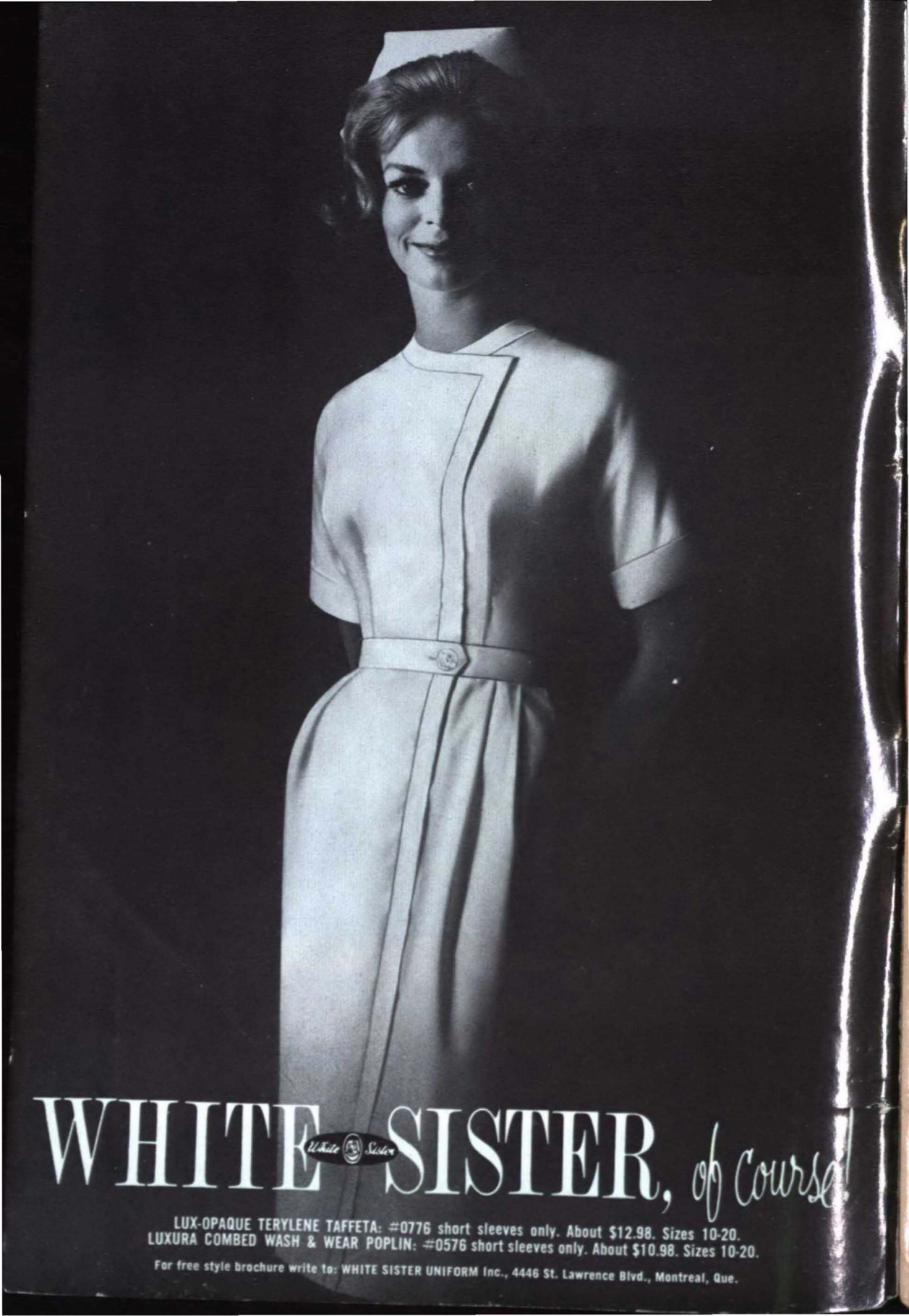
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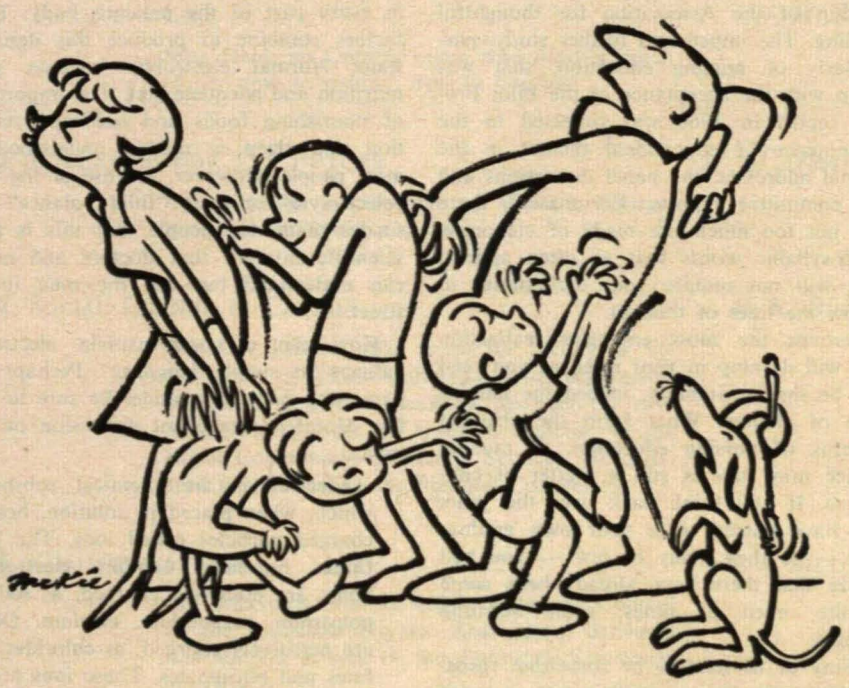

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# Between Ourselves

With this issue, most of the addresses delivered at the 1962 convention have been made available to the general membership of the Association for thoughtful reading. The impetus to further study, particularly of nursing education, that was given with the acceptance of the Pilot Project report in 1960 was reflected in the prominence of educational themes in the formal addresses, the panel discussions and the committee reports. Fortunately, there was not too much use made of elaborate, multi-syllabic words that so often appear. You will not require your dictionaries to follow the lines of thought.

Perhaps the most emphatic realization that will develop in your mind as you read will be the inevitability, indeed the imminence of change. What form the changed patterns of nursing education, of nursing service may take is still a matter of conjecture. If you think back over the years that have passed since your own graduation — be they many or few — you will realize that there have already been some definite, even at times, some startling changes.

Many of us tend to be somewhat resistant to change. It is so much easier, so much less demanding on us personally to stick to a well known, well travelled path whether in our daily routines, our work or our play. Some of us are adventurous enough that we deliberately seek change — so long as it does not conflict with our need for a feeling of security. We at the *Journal* are very much aware of this frequent urge to change that many nurses have as we handle the thousands of new addresses that pour in. That kind of change is reasonable and anticipated. But change in work patterns, in our status as nurses, in the very structure of our professional life — sometimes we are afraid!

Fear can have a devastating influence. It numbs our capacity to understand, to develop, to plan ahead. President Franklin D. Roosevelt once said "The only thing we have to fear is fear itself." Since change is a world-wide phenomenon today, let us challenge our fear of it by giving our complete cooperation to those who are working toward and responsible for the changes that will come in nursing.

Healing of any wound or injury to the body proceeds more speedily and efficiently when there is good physiologic functioning in every part of the patient's body. Three factors combine to produce this desirable state: Normal electrolyte balance, good nutrition and adequate rest. The importance of nourishing foods and sufficient relaxation and sleep is readily understood by most people. However, the use of the term "electrolyte" or even "fluid balance" persuades many lay people that this is some scientific mystery that doctors and nurses can understand but not the man in the street.

How can a nurse explain electrolyte balance in simple language? Perhaps this paragraph may be a guide. Be sure to read Dr. Moralejo's excellent discussion on this topic.

> Electrolytes are chemical substances which, when placed in solution, become charged particles called ions. The body fluids normally contain electrolytes. Some are positively charged, as sodium, potassium, magnesium, calcium. Others are negatively charged, as chlorides, sulfates and phosphates. These ions are essential for the normal functioning of the body and are important also for exerting osmotic pressure which allows water to pass through semipermeable membranes. When electrolyte balance is upset the body does not function properly. *Fundamentals of Nursing*—Fuerst and Wolff.

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Two Saskatchewan doctors have made what is being called "a major breakthrough" in the fight against schizophrenia. Their theory that schizophrenia is caused by a biochemical fault has been proven correct recently by research at the Harvard Medical School.

This discovery by Drs. A. Hoffer and H. Osmond could mean schizophrenia may be detected earlier by chemical means and eventually a compound found that will cure schizophrenia completely.

—*The Financial Post, Dec. 16, 1961.*

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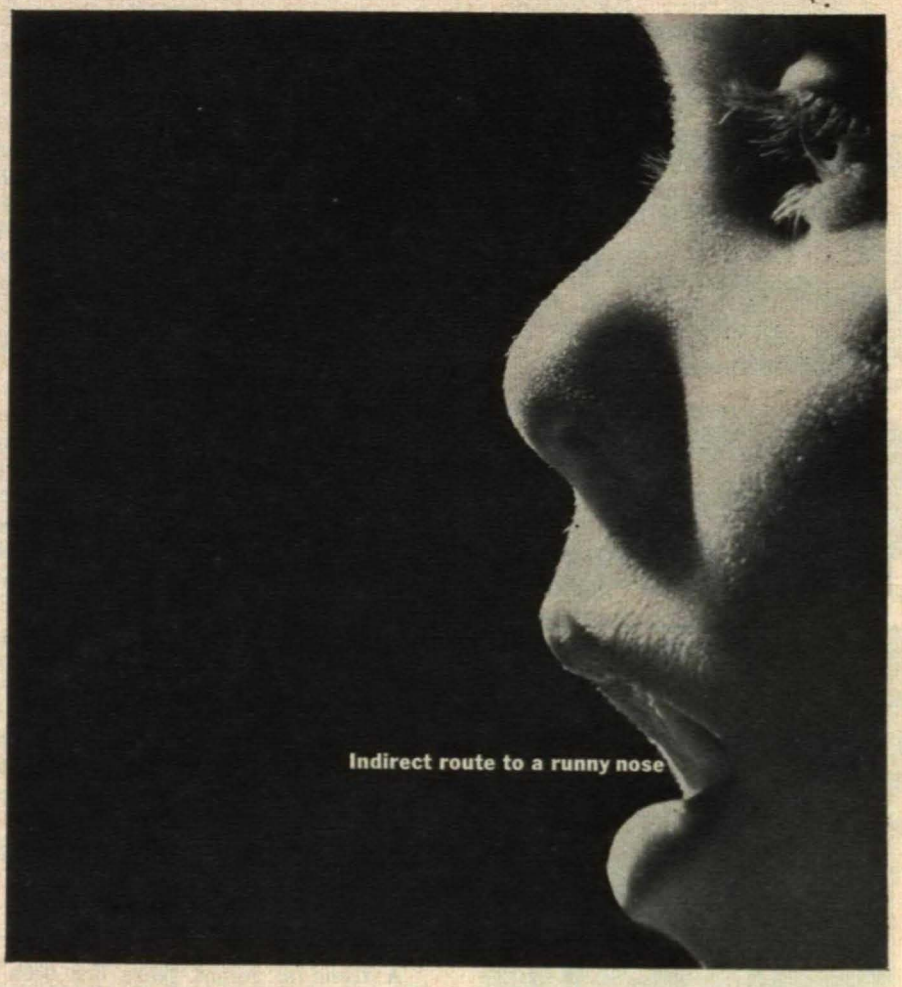
***The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.***

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# *Random Comments*

Dear Editor:

I am a Norwegian nurse, now living in Canada, and have received several copies of *The Canadian Nurse* from a friend here.

I must tell you how much I enjoy reading these journals and what a wonderful "teacher" they are. I feel it is most important to learn about new nursing methods and drugs. As I am unable to do active nursing now, because of my family, it is especially important to me to read the *Journal.*

May I again express my gratitude and ask you to send me a subscription.

Mrs. Laila Skjold, B.C.

* * *

Dear Editor:

I hope that I may be forgiven for asking you to publish a reminder. During a patient's dying hours his tongue should be kept moist and his lips glycerined. Sometimes a nurse is so distressed for her patient that she forgets to ease his passing by a few drops of water and glycerine.

Just a visitor, B.C.

* * *

Dear Editor:

I would like to thank the editors of *The Canadian Nurse* for many months of interesting reading. I have found the articles both varied and stimulating.

(Mrs.) Jean M. Kurbis, Sask.

---

A trend in recent years has been to introduce the young public (high school students) to our general hospitals. The purposes to be achieved by this "open house" method of public relations are recruitment of student nurses and, in some instances, interesting teenagers in doing volunteer work in the hospitals. Whatever the immediate purpose, another purpose was served: to inform — to inform our young public about the inside of a hospital, the institution that is so often depicted in paper-back editions as exciting, dramatic, etc. which often results in its being considered terrifying to the imaginative reader.

The latter purpose was the primary purpose of a tour for high school stu-

dents that was arranged by the Ottawa Branch of the Canadian Mental Health Association. Seventy-six students from Ottawa visited the Ontario Hospital, Brockville and the summary comments of one of them point up the value of such an undertaking.

"Before this visit not many of us realized that mental illness is only a disease and that nearly 80 per cent of the patients leave the hospital within a year. Most of us thought that they would be bed-ridden and lack all freedom. We expected to see them all in strait jackets and were very surprised to see them wandering around generally doing what they pleased. We also expected to be able to tell the difference between a mentally disturbed person and one of us found no noticeable difference. The patients seem very talented. Women were doing leather work and sewing, while the men did wood-work and painting. Even though the rooms we visited were locked behind us, we didn't get the feeling of being shut in with no way out. Some patients roamed the grounds quite freely.

After our visit we felt we had gained a 'pound of knowledge'. We all agreed that people should be better educated about mental illness and that there should be more hospital tours. At least the students who took advantage of this opportunity to visit now know what the inside of a mental hospital is like."

—Quoted in *Canada's Mental Health*, Vol. 10, No. 4.

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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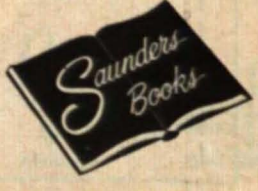

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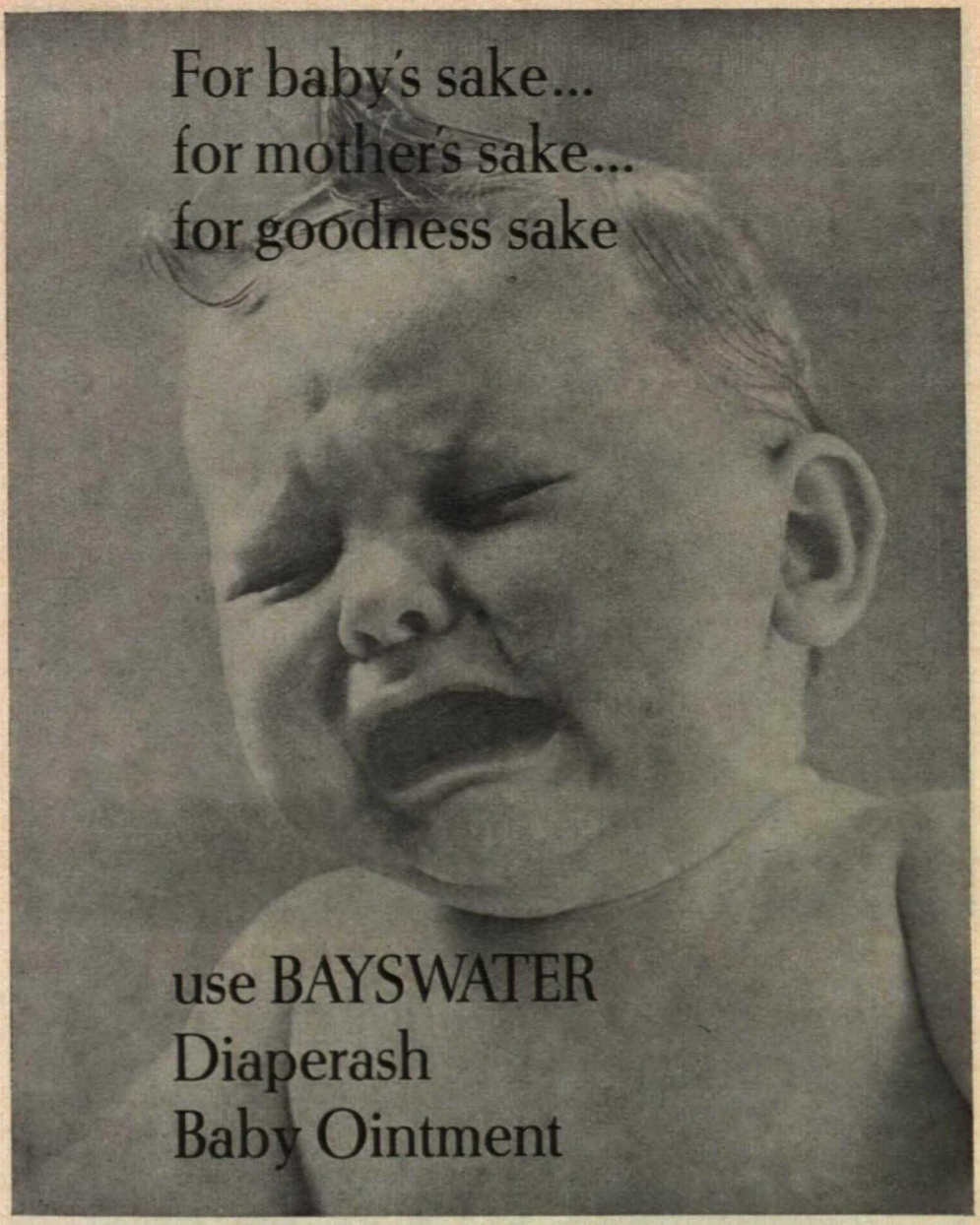


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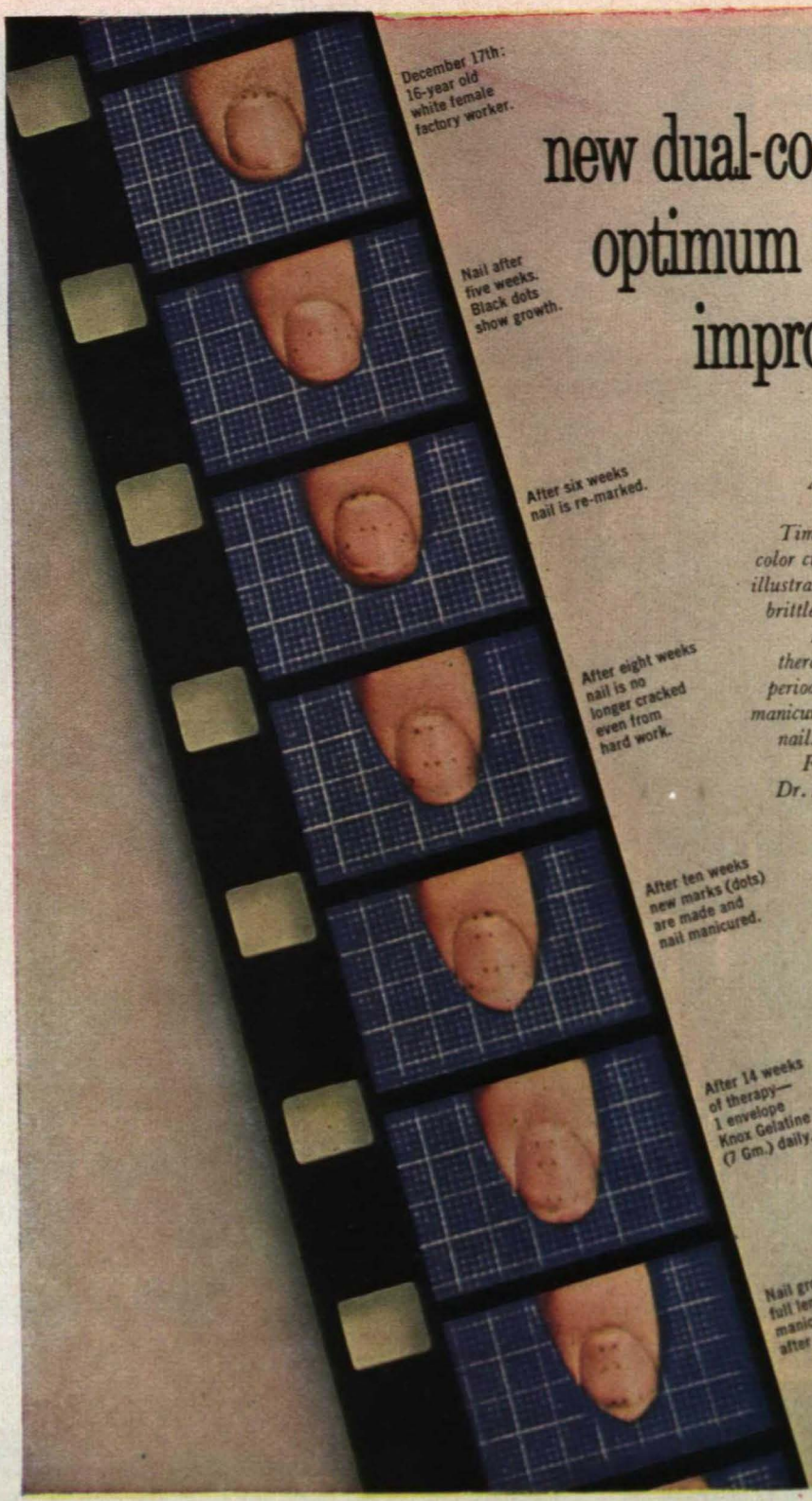


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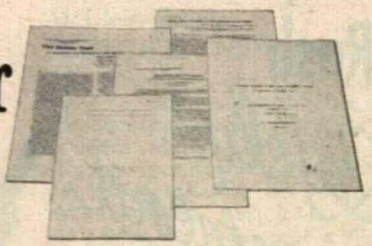

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- ☐ 1. Derzavis, J.L. and Mulinos, M.G.: Med. Ann. D.C. XXX:133, March, 1961.
- ☐ 2. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September, 1957.
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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
Fischer, C. C. and Lipschutz, A.; Am. Jour. Dis. Child, 89:5, 596, May 1955
Benson, R. A., et al: Arch. Ped., 73:250 - 8, July 1956

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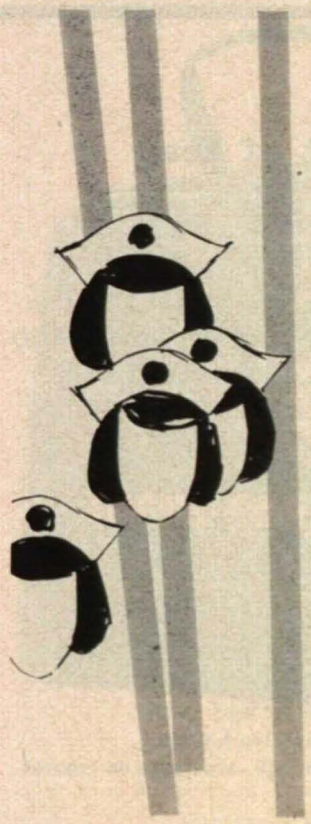

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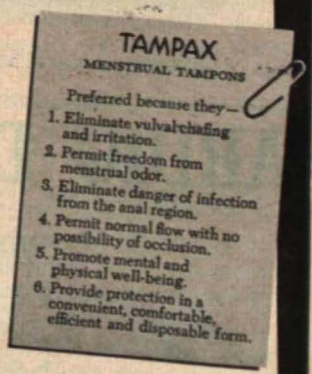


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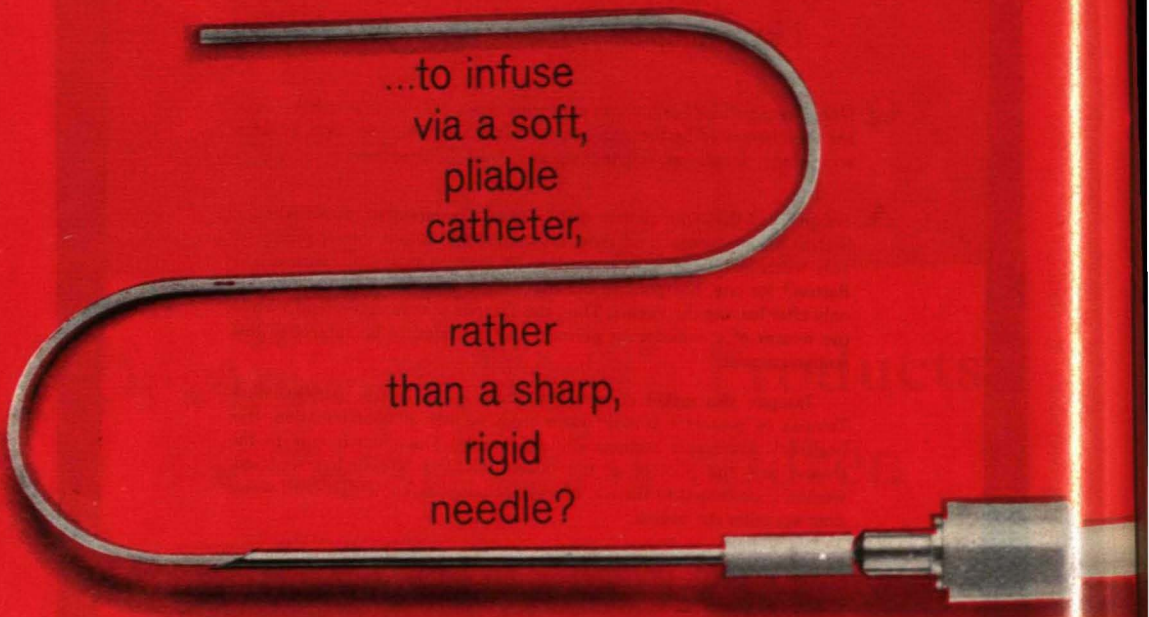

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BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 58 MONTREAL, OCTOBER 1962 NUMBER 10

## TO LIVE A LIFE

To build a house; to rear a child; to write a book. Any one of these three enterprises could be the consummate goal of a human's aspirations. Each calls forth our deepest faith and a belief that what we are doing is all-important. Each one, also, shows a belief in posterity — a desire to leave something after we are gone. Blind Dr. Munthe who planted the trees around San Michele on the Isle of Capri did not plant his trees because he could view his handiwork but so that the trees might offer their fruit and their shade, their beauty and their majesty to a generation not yet born.

Every time we do something for tomorrow, or plant the fruit for those yet to come, we become part of the Eternal rhythm of the Universe. We are trying to give back something of our belief and faith to a world from which we have received so much. Yet, it is true, not everyone who sows will again plant; not all who have children will rear them. To build a house; to rear a child; to write a book calls for a love which abides. Life grows only in response to interests and concerns that continue. If the house is not repaired and the child not tenderly cared for, they remain in a state of half-completion or stunted. So many of our good intentions stand as broken promises. Their tragedy reflects our own. We each have within us the ability to produce something lasting but our faith lacks stamina.

Few books are written that remain alive. Love stories may be cheap and, if they are, they are quickly tossed out of the mind. Stories in which there is majesty and heroism, with characters representing the greatness of human heart and nobility of soul, live on.

Life is a book that we author. Long after we have departed the writing remains for others to read. If our concerns and interests have been trivial and narrow, our intentions irrelevant, our lives too will die on the nearest scrap heap. To write a book that will be read — that is not the challenge. But to write a book that will be *remembered* — that is!

To live a life is not enough. To live a life for a purpose and to see that purpose is good — that is a book we can all author.

— DOROTHY M. DENT

# EDUCATING for the FUTURE

W. HARRY HICKMAN, PH.D.

*The keynote address of the 1962 biennial convention.*

EACH time that we receive or post letters we are reminded, by means of a five-cent stamp depicting youth and the symbols of learning, that 1962 is Education Year in Canada. This stamp was issued on March 4, the first day of the second national Conference on Canadian Education. The huge gathering did not solve any problems but it aimed at communicating to our nation the urgency of rising enrolments, rising costs and rising interest in all schools from kindergarten to university. Everything in education may double in a decade. By 1972 will there be twice as many nurses to serve twice as many patients? Will there be twice as many nursing schools which therefore will require twice as many highly trained instructors?

## Conference on Education

Dr. Trueman, chairman of Canada Council, summed up the 1958 Conference by saying that there were not many problems in Canadian education that could not be solved by more money. Dean Scarfe, Faculty of Education, UBC, twisted the remark in 1962 by stating that there were not many problems in Canadian education that could be solved by more good teachers. The conference centered around nine topics, the first five at least if indeed not all of which are of intense interest to nurses:

The aims of education
Financing education
New developments in society
Continuing education
The citizen in education
Education and employment
The professional status of teachers
The development of student potential
Research in education

We have learned a great deal but we have more to learn each day in order that we keep ourselves aware of new developments in society. These were discussed under such headings as:

Growth of knowledge
Technical developments
Social growth and change
Move to city centres
Changes in family structures
Transportation and communications
International problems
National unity

As educators, we are urged to prepare young people for a changing society. To what extent was I educated 30 years ago for the world I now live in? Did the chemistry and mathematics that I studied, and a course called "civics," have much relevance? I believe that my early and continuous exposure to history, languages and literature has served me well, but I am not yet properly adjusted to television and jet flying! Being a true child of the depression, I still have a very false idea of the value of a dollar. My generation is not sufficiently well-trained, except by length of experience through three rather chaotic decades, to counsel young people now entering high school or university. Of course this has always been so, but changes are so alarmingly more rapid. If society changes in the same progression as over the past 20 years, what do we

know of the world of 1982? Our imaginations are not visionary enough to predict what a dollar will be worth; to what extent the world's population will have exploded; how and how fast we shall be travelling; where political balance of power will be teetering; to what extent learning will be mechanized; to what extent the State will have assumed responsibility for our grandchildren's welfare, education, health, work, leisure and morals.

In spite of all this, I am certain that the family unit will survive, that it must remain as the stabilizing element for the individual. As always, church and school are important influences which supplement the home. They are two agencies which will have to struggle actively and intelligently to maintain their roles. The family must not slough off its responsibilities for, in a complex, efficient, speedy world, man needs to find a haven, a small unit in which he is an important individual human being. As churches become larger, as schools and school systems enlarge, as hospitals become bigger, and all therefore, become more efficient, more impersonal, more inhuman, the home, in spite of new tensions and sociological phenomena which assail it, is an understandable, "encompassable," intimate human unit. In the home can be fostered the importance, the dignity, the freedom, the curiosity, the imagination of the individual.

When you return home, people will ask you, and indeed you will ask yourself, if conventions like this one are worth while. Did you accomplish anything? Did you learn anything new? If conventions have grown to such proportions in recent years simply from a desire for "togetherness," let us not underestimate the advantages of meeting and chatting with one another, of renewing friendships, of cultivating tolerance and understanding. It is at national conventions that Canadians become aware of our two cultures. Bilingualism was a frequent topic of discussion at the Conference on Education. Dr. Wilder Penfield, Canada's distinguished scientist who believes in the early teaching and learning of more than one language, urged once again, the use of family exchanges and other practical and direct ways of learning a second language in order to cultivate and cherish our Canadianism. I am certain that you feel like Canadian nurses. Are there better trained nurses in the world? Are there more respected nurses elsewhere? Are there better organized, more closely knit associations of nurses elsewhere? Are there more ambitious, more professionally-minded nurses elsewhere? Exactly which Canadian characteristics do you wish to maintain and develop? Have you counted all your blessings? All your challenges?

After four days of meetings in Montreal, the closing address was given by Dean Leddy of Saskatoon. I was so moved by his words about being a Canadian that I wish to quote a few of them :

> Canada, we sense, is a special place, blessed of Providence, preserved from the undeserved misfortunes which have overwhelmed better people. I do not know why this should be so, and I avoid any complacency in making the claim. I seek the concurrence of my fellow Canadians, both French and English in language, in acknowledging the remarkable good fortune, without parallel in history, which has so attended us. But reflecting on these things I am prompted to assert that of all the countries in the world, without exception, Canada is most favored in one respect — the remarkable combination of circumstances that sets us apart, without rivalry, as the freest and finest of countries in which to live. Obscurely, sometimes, Canadians know this, seeking to come back to Canada from the United States, or Great Britain, or some other country, not quite sure why they desire to do so.
>
> In my view they have sensed something which calls for explicit recognition : That Canada enjoys unusual equality in social, in economic, and in political conditions. There are other countries with a claim to greater equality in some *one* of these categories than we can pretend. I would suppose that the United States might present a more impressive record of economic equality, on the whole, than we can offer; that the United Kingdom could point with pride to a more sophisticated level of political development. Such concessions one might make, but I would affirm, with much emphasis, that Canada is unique in its

portrayal of these three fundamental equalities, taken in combination and in their interrelated unity. I would declare that nowhere in the world are there men and women more fortunate than we are, set upon the stage of the twentieth century, less burdened than anyone in history . . .

We are the most fortunate of men in Canada, indulged by history more than those in any other country. Let us acknowledge our undeserved prosperity; our free access to full knowledge; our freedom from mean constraint. Let us, in gratitude, turn with enterprise, with vigor and generosity to the full development of education in Canada at every level, for our own sake and for the men of other countries whom Providence has given us, in spite of our unworthiness, as elder brothers.

We have had great and golden ages in the past, accomplished by rough military power and overwhelming financial affluence. Today, for the first time, in such countries as Canada, we hear a call to achievement and endeavor addressed to countries of no such pretensions. We welcome it and we shall not fail.

## Changes in Teacher Education

Although there are many differences, I thought that I might comment on recent developments in teacher education, of which I have some knowledge, so that you might compare them with problems in nursing education. It is significant that in both cases we have abandoned the word "training" and substituted "education" of teachers or nurses. It is interesting to note that there are approximately 20,000 of each profession in Canadian schools this year, although such numbers do not mean much since from province to province, the length of teacher training programs varies from one year upwards. Quite obviously these two professions are peopled mainly but not exclusively by women. In both professions there is a strong trend in the direction of university programs, both undergraduate and postgraduate.

Twenty to thirty years ago nurses and teachers were perhaps more respected for their knowledge and service than today when the public wants its money's worth and expects service for which indeed, and fortunately for us all, it does pay more. Pedestals have disappeared. Mystery has vanished. If some of the old-time respect has gone, this does not mean that the nurse and the teacher cannot enjoy a more humanized, more dignified status that befits our age, our democracy, our society.

In the Western provinces, as you know, normal schools have disappeared. All teacher education is undertaken on a university campus. British Columbia no longer has a one-year training program following Grade XII, not even of the so-called emergency type. The present two years of university work, supplemented by much practical experience in the classroom, will soon give way to a three-year basic course. Before too long, most teachers will complete a university degree in education : a four-year course for elementary school teachers and a five-year course for secondary teachers. I am proud to say that the curriculum is 70 per cent academic, composed of liberal arts courses, and 30 per cent professional. It has often been calculated that it is possible for both teachers and nurses to master sufficient, basic facts, techniques and methods in 12-15 months. However to be a good teacher of children, a good nurse of human beings in this world so frequently and rightly described as changing, complex, and scientific, much more is necessary than basic training and method. One has to be aware of the community and the world; feel part of a vast explosive situation; know something of past thought and philosophy in order to assess oneself, to understand one's fellow man, and to imagine the future. Courses in history, literature, psychology, sociology, economics and the fine arts help us to understand the strains under which we live; help us to enjoy life and to direct others to similar enjoyments.

I believe that it is restricting to train teachers in normal schools in isolation so to speak, as so many training colleges still are doing in Britain. Surely it is preferable to educate teachers on a campus where they experience more freedom and where they rub shoulders and exchange ideas with other pre-professional groups. This move may help to break down Mr. Public's attitude that teachers are a bit different !

Perhaps there is an analogy with

nursing. Would there not be advantages to escaping from the hospital atmosphere and to mingling with young men and women who intend to be lawyers, social workers, engineers, librarians, doctors and teachers? Three of the many obvious by-products of the move to a university campus are :

1. University graduates are likely to pursue postgraduate studies. Universities provide courses that are especially valuable to people who, having practised a profession, feel the need to return for more specialized training.

2. Far more research is now undertaken in an academic institution. For nurses, no doubt there is still much to be studied in the field of community services.

3. Instructors are trained. In my field as well as yours, the greatest lack is that of teachers of long and varied practical experience who have one or preferably two academic degrees beyond the baccalaureate.

These three and other benefits accrue slowly and in spite of severe outcries such as : Too much theory and not enough practice in university; courses are too costly; courses are too lengthy to attract sufficient recruits. Our experience in the College of Education in British Columbia has been that, in the six years following the change-over, total enrollments have risen from 1136 to 3012. We are preparing nearly three times as many teachers — not yet enough — and of course, I admit that enrolments in Canadian universities have been showing comparable increases in many other faculties. I would like to assure everyone that practice teaching, which is equivalent to and just as essential as your clinical experience, has not been short-changed. Statistics from the Victoria College Director's report of 1962 show that total observation and practice teaching in the one-year Victoria Normal School Program was *263* hours. Our present two-year elementary program includes *330* hours of observation and practice teaching — a 25 per cent increase in practical work !

Canada's pioneer-type programs for professional training will scarcely suit future demands. True professionals of the future will require more than three years beyond high school graduation, if only because their clients will be much better educated. It is possible that before long senior matriculation or first year arts and science, will be a requirement for admission to both teacher education and nursing education. At present our teachers are required to have at least two university courses in English, one in Canadian history and one in science. I feel strongly that liberalizing courses should not be too specialized. I am opposed to English for engineers, Canadian history for teachers, sociology for nurses. General but profound courses can accommodate all pre-professionals. As a non-scientist, I would like to have a course in the history and philosophy of science, in scientific method, and in the application and meaning of science to our day. Universities are prone to give freshman chemistry for potential chemists, zoology for premedical students, and yet these are the only courses available to all other freshmen. Some sort of compromise, without a lowering of standards, would, I confess, be difficult to achieve. Nevertheless, we should try, experiment, and avoid falling into C.P. Snow's definition : "The American cultural climate is a mood of caution and complacency rather than one of moral audacity and social indignation."

## Problems

I assume that your Association has considered and will continue to study the possibilities of introducing more broadening and humanizing courses into your educational programs. Doubtless you are in favor of the university nursing course that began at UBC in 1919 and that is now offered in many Canadian universities. I gather that you are in favor of having all final controls of the candidate's program vested in the school of nursing in order, partly, that a varied clinical experience in many institutions and areas may be planned for the student.

Many problems of teacher education and nursing education exist. They will not be solved this year or next. How shall we maintain a balance in our study of the sciences and of the human sciences? How much uniformity across the country is practical and, indeed, desirable? By what date shall we have

highly trained master teachers and nurses in sufficient numbers for instructional purposes? What is the best curriculum for training, for living and serving in 1970, 1980, 2000? To what extent must we protect the individual against the masses, against the system, against efficiency, against an over-organized, over-unionized, over-materialistic society?

Let me say, emphatically, that we must never underestimate the worth of the teacher or the nurse who has succeeded with a two- or three-year training period and with sound experience. She must not feel inferior if we talk of lengthening and broadening programs in the future. We admit that many of Canada's best teachers had minimal training; that they went into a classroom at the age of 18, inspired, enthusiastic, devoted, loving humanity and succeeding miraculously. However, they moved in a small world, in a pioneer community, among simple, appreciative people. Tomorrow's teacher and public health nurse will need to teach, to interview and to counsel with some understanding of the changing socio-economic environment. How trite to say that status quo thinking would result in stagnation and disrepute for any profession!

## A More Liberal Education

Do you think that we are expecting too much of the nurse of to-morrow? Can she be a scientist, a social scientist and a humanist? Is she to be a thinking nurse, a well-read nurse, an educated nurse, as well as a practical nurse? She must have her own life, too, in a complex society. She may be a homemaker, a wife, a mother and, at the same time, a professional person. Is there time for all of this?

I recently attended a meeting of the Learned Societies. While we were listening to papers on esoteric subjects such as the influences of the Latin poet Lucretius on the French philosophers of the 18th century, or a modern interpretation of *Aucassin et Nicolette*, formerly considered a great love story of medieval France, now revealed as a parody on idyllic love, what were the members of the Canadian Conference of University Schools of Nursing discussing? More practical matters no doubt. I have been much impressed by the quality of your research and statistics and your submissions to Royal Commissions. I have read Miss Helen Mussallem's excellent *Spotlight on Nursing Education*. I cannot refrain from quoting three sentences:

> As schools were surveyed and conferences held with people both within and without the profession of nursing, there was general agreement that the present system of educating nurses should be re-examined in the light of social changes and the present and future needs of society for nursing service.
>
> . . . The preparation of the nurse should be an educational experience and the method by which this can best be achieved is through a school which plans and controls the complete experience of the students . . .
>
> The education of nurses should . . . have . . . the same financial support as that afforded other professional education.

After putting together my few thoughts on education as they might apply to nursing education, I delved into C. H. Russell's book, *Liberal Education and Nursing*. His three concluding paragraphs are so applicable that I quote:

> Nursing education is now obviously ready to take quick and long steps toward the goal of a more liberal education for nurses. Much must be done to change prevalent ideas among members of the profession, educators generally, and the public, if solid support is to be gained for an enhanced program of liberal arts instruction in nursing curricula. The professional course must be revised to allow an increase in non-professional subjects and to bring technical instruction into conformity with the larger purpose of all higher education. Fortunately, nursing education and the profession at large has its full share of courageous leaders who fear neither innovation nor the inevitable criticism that accompanies it. The leaders of the profession have the vision of the value of a sound liberal education in the improvement of nursing professionally, publicly and materially.
>
> By making the values of liberal education central in its educational program, nursing can show the public that some thing more than a skilled specialist is needed to serve the nursing needs of modern society. By increasing the breadth of the student's edu-

cation, it can provide the intellectual vitality necessary for long-term growth and the capacity to adapt to the ever more complex tasks and accelerating changes in the health services. By giving greater attention to those areas of learning that provide understanding of life as a whole, these schools will prepare the nurse to assume a larger share of responsibility in general community life and thereby increase public recognition of her position. Moreover, enlarged opportunity for personal development inherent in a fuller and richer education will attract high calibre students to nursing.

It is essential that professional groups take initiative now to preserve the heritage of liberal learning, for in an age in which man's highest achievements may number his remaining days with orbital precision and cosmic power, the human wisdom that springs from genuine liberal education is of momentous consequence. No group which would aspire to the elevated status and position of professional leadership can, in the present, fail to make liberal education an integral component in the education of its future members. This is the challenge which faces the ancient profession of nursing.

Each person will strive in her own way to achieve her own high ideals. In some ways, her tasks will be easier. There will be more preventing and less curing. Many processes will be mechanized. However, one of my colleagues, another teacher of French, said when we decided not to instal a language laboratory at Victoria College: "I do not wish to have a mechanical gadget coming between me and my pupil." I am certain that you do not wish electronic devices of the future to separate the nurse from the patient.

In Canada, we of the public need not be worried about the kind of nursing services we receive. Your Association is active, dedicated and watchful. You are concerned not only with the rather dull questions of constitutions, commissions and salary schedules but also with the good health of all Canadians, believing in both prevention and cure and able to do something constructive about both.

## Cherished Values

Perhaps it is because I have been attending meetings of the Learned Societies that I have, by reaction, spoken in such simple terms. I hope that I shall not sound too trite, too sentimental in my concluding words. I shall hide behind quotations and our other Canadian tongue! Among the values that we cherish and attempt to cultivate are friendship, human relationships, faith, a sense of responsibility, the awareness of being Canadian, the privilege of being able to continue to learn and to serve.

I am fond of quoting a modern French author who places two of these qualities above all others. They are human qualities that will probably see us through the days of materialistic and mechanized society, the days of selfish speed and scientific efficiency that lie ahead.

Nurses establish friendships within their own group and with mankind. They have an appreciation of the luxuries that money cannot buy. Writing of comradeship among aviators, Saint-Exupéry* said:

*La grandeur d'un métier est, peut-être, avant tout, d'unir des hommes: il n'est qu'un luxe véritable, et c'est celui des relations humaines.* (The great value of a vocation is, perhaps above all, the union of men. Human relationships are a genuine luxury.)

*En travaillant pour les seuls biens matériels, nous bâtissons nous-mêmes notre prison. Nous nous enfermons solitaires, avec notre monnaie de cendre qui ne procure rien qui vaille de vivre.* (If we work for material wealth alone, we build a prison for ourselves. We shut ourselves up alone with our currency of ashes which buys nothing of value to living.)

*On n'achète pas l'amitié . . . d'un compagnon que les épreuves vécues ensemble ont lié à nous pour toujours.* (Friendship cannot be purchased . . . the friendship of a companion bound to us forever by past hardships.)

In two poetic sentences, Saint-Exupéry describes the double delight of a solitary night flight and the safe arrival at dawn in this world of beautiful nature and friendly people. Compare it, if you will, with one of your

*Saint-Exupéry, a native of France and a noted aviator and writer, established intercontinental mail service between Europe and South Africa in the early 20's.

long and successful night vigils and with your feelings as you walked into the early morning sunshine, aware of trees and flowers and of friends around you.

*Cette nuit de vol et ses cent mille étoiles, cette sérénité, cette souveraineté de quelques heures, l'argent ne les achète pas.* (Money cannot buy the peace, the sense of supreme power, the thousands of stars, of a night flight.)

*Cet aspect neuf du monde après l'étape difficile, ces arbres, ces fleurs, ces femmes, ces sourires fraîchement colorés par la vie qui vient de nous être rendue à l'aube, ce concert des petites choses qui nous récompensent, l'argent ne les achète pas.* (This new glimpse of the world after a difficult step — the trees, the flowers, the women, the smiles, freshly colored by the life restored at dawn, this harmony of little things that reward us — money cannot buy them.)

The other virtue that Saint-Exupéry so frequently extols in his novels is that of responsibility which he places above wisdom or courage. It is the responsibility of the old gardener who fears death only because he has so much digging and pruning still to do. It is the responsibility of pioneer aviators, like Saint-Exupéry himself, who worked to establish links between peoples of different continents. It is the sense of responsibility known to every nurse.

*Sa grandeur c'est de se sentir responsable. Responsable de lui, du courrier et des camarades qui espèrent. Il tient dans ses mains leur peine ou leur joie. Responsable de ce qui se bâtit de neuf, là-bas, chez les vivants, à quoi il doit participer. Responsable un peu du destin des hommes, dans la mesure de son travail.* (His greatness is his sense of responsibility. Responsible for himself, for the mail and the comrades who hope. He holds their grief or their joy in his hands. Responsible for what is being built anew among human beings, in which he must take part. Responsible in some degree for the destiny of man in the course of his work.)

*Etre homme, c'est précisement être responsable. C'est connaître la honte en face d'une misère qui ne semblait pas dépendre de soi. C'est être fier d'une victoire que les camarades ont remportée. C'est sentir, en posant sa pierre, que l'on contribue à bâtir le monde.* (To be a man means to accept responsibility. It means to feel shame in the face of misery which apparently is not of his own doing. It means being proud of others' victories. *It means feeling that, in placing his stone, he is contributing to the building of the world.)*

I know that nurses must experience the satisfactions of responsible tasks well done as they make their important "contributions to the building of the world."

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Some few months ago a poll by four Canadian newspapers made the Canada Goose an overwhelming choice as Canada's national bird. One paper said the Canada Goose polled twice as many votes across the country as all other birds combined.

The Canada Goose was favored because it may be found in every province in Canada. "It is strong, intelligent, and faithful to one mate" and as one voter said "it is a proud big bird suitable to represent a proud large country".

When the late Jack Miner, Canadian naturalist, founded the Jack Miner Sanctuary in 1904, Canada Geese had become so scarce that he kept his decoys four years until any joined them. In 1908 some 11 Canada Geese alighted at the Sanctuary. In 1909, 32 came and in 1910, 350 came. Since then by having Jack Miner's Sanctuary and hundreds of other suitable sanctuaries on the continent patterned after it, Canada Geese have increased.

* * *

A child may develop a squint, either pointing in or pointing out, at an age as early as six months — occasionally a baby is born with one . . . Immediate treatment is essential because a squinting eye becomes passive and increasingly weak-sighted — the longer it is left the less chance of full discovery.

—*World Health*, March-April, 1962.

* * *

Most troubles do not enter without an invitation.

# Social Change in Canada

BERNARD R. BLISHEN

*The terms "Canadianism," the "Canadian image," the "Canadian identity," are bandied about on every side today, but in reality they say very little. What they do indicate is that we, as a nation, are concerned with how we see ourselves as inhabitants of this political entity we call Canada.*

EDWARD SHILS says that all human societies have some inarticulatable essence of their own.* There is something about the way in which we have organized our affairs in this country, whether they be the peculiarities of our political, economic or social systems, which give us a sense of affinity with our society.

## A Growing Awareness

I mention this emerging self-consciousness because I believe it is a reflection of a stage in our development. Canada has all the appearances of a modern industrial society but, if you probe deeply, you will find that the trappings of modernity are a façade covering a great deal of irrational thinking. This confusion simply means that we have not made up our minds about the meaning of our material success, and the economic, political and social factors that have brought it about. When we look at ourselves, we do so in a peculiarly comparative way. We have difficulty in specifying our uniquely Canadian characteristics so we tend to compare what we do with what is being done in other countries. For example, when we think and talk about our political activities we compare them with similar activities in the United Kingdom. We like to pride ourselves on the fact that we are very similar in many respects. On the other hand, if we think in economic terms we take the United States as our model. We say, among other things, that we are second only to the United States in our standard of living. We tend to switch the models with which we compare ourselves according to the situation, but seldom do we say that *this* idea or *this* activity is something that is uniquely Canadian. I think this stems from our tradition of dependence, both economic and political.

At the beginning of this century we were economically, and to a great extent politically, dependent upon the United Kingdom. This arrangement persisted until shortly after the first World War. At that time, the United States began to supersede the United Kingdom as the predominant investor in the exploitation of Canadian resources. This was followed by the emergence of the United States as one of the two great powers with whom we allied ourselves and upon whom we relied for political and military leadership. We switched, then, from dependence upon one country to another. We seem to have a habit of depending upon something outside our borders as a standard by which to measure ourselves. This, of course, is complicated nowadays by the fact that the world is becoming nationally interdependent. In other words, Canadians are becoming aware of themselves — they are becoming nationalistic — just at the time when, certainly in the Western world, nationalism is not only outmoded but dangerous.

## Social Changes

I have mentioned this emerging concern with our identity because it should not be confused with the type of social changes I shall discuss. The two developments must be kept separate, otherwise we will tend to think of particular

* Shils, E.: The False Prospero. *Encounter*, 94, July 1961, p. 83.

economic, social, or political changes as uniquely Canadian, whereas — and this point must be stressed — in the main they are no different except in degree, from similar changes taking place in other highly industrialized nations.

### Population

One of the most obvious characteristics of any society is the size of its population. This is something we can all understand. Like money in the bank, it is measurable. It can be compared with that of other societies and thereby arouse feelings of pride or chagrin depending upon the society with which comparison is made. This is particularly true of North Americans to whom size is equated with progress and the good life. Three hundred years ago Canada had a population of 3,215. Today it stands at over 18,000,000. This increase is due to a variety of factors. The decline in mortality, especially infant mortality, brought about by advances in medical knowledge and technology has resulted in an increased life span so that we, like other Western industrial societies, are faced with an increasing proportion of aged persons in our population.

The average size of the Canadian family had decreased for many decades prior to 1951 but in 1956 it showed an increase. The actual increase was, admittedly, very small, but it seemed to reverse a decline that had persisted for about half a century. A further increase occurred in 1959 and still continues. This was, in some measure, due to an appreciable increase in the birth rate between 1941 and 1956 and to a greater proportion of the population entering the married state. The latter proportion increased from 51.6 per cent in 1901 to 65.8 in 1956.

### Immigration

Another important factor in Canada's population growth was an influx of immigrants. Between 1941 and 1956 a total of 1,247,000 arrived here. We suspect that, unlike previous waves of immigrants who used this country as a stopping-off point on their way to the United States, most of those who arrived after the last war became permanent residents. The emigration of the immigrant was a factor in Canada's slow population growth in the early decades of this century.

### Ethnic Factors

An important consequence of the inflow of immigrants is our ethnic heterogeneity. We tend to think of our country as having two main ethnic groups, British and French, with the latter concentrated mainly in the province of Quebec. This pattern is changing. While the proportion of French origin remained relatively stable at approximately 30 per cent between 1901 and 1951, that of British origin declined from around 59 per cent to just under 48 per cent. This decline was due to an increase in the Italian, Dutch, Polish, Scandinavian and Ukrainian groups. I expect that when the 1961 census figures are released the proportion of British will show an even further decline, while some of the other groups will show increases. Should these trends continue among the non-French groups, with the French showing small but steady gains in successive decades, it is possible that Canada will one day be predominantly French. This is, at best, a very shaky assumption. As you all know from fairly recent events immigration can be very appreciably slowed, and even stopped, with the stroke of a politician's pen.

### Patterns of Religion

The changes in the ethnic pattern of our population are matched by changes in our pattern of religious denominations. Roman Catholics are by far the greatest percentage of the population — just over 43 per cent in 1951 — and if the evidence from past censuses is a reliable indication, they will maintain this predominance. The Protestant sector of the population is fragmented into a variety of denominations with the United Church being the largest.

I have mentioned this ethnic and religious diversity because it indicates the pluralist nature of our society. By this I mean a society which is fragmented into numerous groupings — ethnic, religious, professional, and regional, to name only a few — but which has an underlying consensus that tends to bring some of these groups

together in situations requiring collective action. One of the curious features of these collective ideals for English-speaking Canadians is their duality. As I have noted already, because of what I have called our tradition of dependence we tend to use England and the United States as models for much of what we do. At the same time each of these countries stands for cherished and disliked ways of acting, and together help to constitute a Canadian sense of identity which, as a result, is more often decided about what it is *not* than about what it wants to be. †

The effects of this social heterogeneity are very noticeable in the political sphere where decisions are made affecting every aspect of our daily lives. At every level of government, but especially at the federal level, policy decisions are sometimes delayed until representatives of all groups have had a chance to express their views. This can be done through a royal commission, or through direct representation to the government of the day in an annual brief. This process of reaching a decision is sometimes time-consuming but tends to focus the attention of diverse groups on particular issues. In one sense, it makes them partners in a common enterprise, and thereby increases the collective consensus.

### Population Shift

There is one other demographic trend that should be mentioned. The rural-urban shift in our population has changed our society from a predominantly rural to a decidedly urban one. If you examine 1901 census material, you will see that just over 62 per cent of the population lived in rural surroundings. This continued until 1931 when, for the first time, the largest proportion lived in urban areas. In 1956 we were 66 per cent urban, and 1961 census data show this proportion to be just over 69 per cent.

### Industrialization

The shift of population has had a number of consequences. In fact, this particular type of movement has been blamed for a variety of ills, but claims of this nature are seldom substantiated. Modern cities are the foci of industrialization, and the process requires rational and impersonal standards for its development. This requirement points up a basic strain in our own and other western industrial societies. Industry is based on rational standards of efficiency, which means that personal ties of kinship and sentiment must not be allowed to interfere with their application. We cannot mix the impersonal and the personal in industry. We apply the first in the work situation and the latter at home. This imposes certain strains on family life.

The impersonality of many of our human contacts in cities is matched by their transiency. We interact with a multitude of other people in a variety of situations in our daily lives. This interaction is regulated by policemen, traffic lights, bus drivers, sales clerks and numerous others who keep us moving, take us from place to place, serve us goods and provide us with services in a regulated, impersonal fashion. These types of contacts, which are characteristic of city life, make us atomized units in an urban industrial complex. This state of affairs is in sharp contrast to the close ties of kinship and sentiment that were the basis of our interpersonal relationships when we lived in smaller aggregates, usually tied to the land. Since the period of rapid industrialization in Canada occurred quite recently many of us can remember, sometimes with regret, what life was like formerly. We tend to contrast the two worlds, the one mainly industrial and centred on the city, the other rural and centred on the land or village. In contrast, the facts of industrial life sometimes seem harsh and demanding. We tend to forget that along with the changes outlined, we have much more leisure time, a higher standard of living, and a longer life span, but I cannot presume to balance the benefits and drawbacks of our transition from an agricultural to an industrial society.

The transition becomes very obvious when one examines our occupational structure. In 1901, nearly 46 per cent of the male labor force followed agri-

† Blishen, B. R. et al.: *Canadian Society*. Glencoe: The Free Press, 1961, p. vii.

cultural occupations. Fifty years later the proportion was just over 19 per cent. On the other hand, occupational categories such as manufacturing and mechanics, construction, transportation trade and finance, professional and personal services, and clerical occupations showed significant increases.

## Women at Work

A significant and increasing proportion of Canada's labor force is now made up of women. A similar trend is taking place in all industrial nations. The increase was most noticeable during the two World Wars when male labor was in short supply, and women were given the opportunity to learn and apply new skills. With the great industrial expansion, characteristic of most Western countries since the last War, has come an increase in the so-called bureaucratic arrangements that service the industrial machine. It is in this type of office work that women are found to outnumber men.

Despite the increase in the participation of women in the Canadian labor force, a six-fold increase in numbers between 1901 and 1958, we still fall behind Britain and the U. S. in this respect. Twenty-four per cent of our working population is made up of women. This compares with just over 32 per cent in the U. S. and nearly 34 per cent in Britain.

A significant feature of the female labor force is the increasing proportion of its members who are married. This is a relatively recent change. In 1931 this figure was only 10 per cent, but in 1958 it was over 40 per cent. A large group of these working married women go in and out of the labor force at a faster rate than men. Those who enter the market as demand rises, and leave it as demand falls, do not have to depend solely on their own earnings. They are usually the second breadwinners in the families.

These changes concerning woman's status in our society are reflected in the changes occurring in the participation of women in the professions. As you are probably aware, women predominate in teaching and nursing, as laboratory technicians, musicians and music teachers, social welfare workers, librarians and others. In other professions, women are forming an increased proportion. This is evident among architects, authors, editors and journalists, chemists and metallurgists, dentists, draughtsmen, designers, engineers and lawyers.

## Specialization

These changes have been accompanied by a trend towards a greater degree of specialization in the total labor force. The rate of specialization appears to be growing; so much so, in fact, that we are frequently confused when we are told a person's occupation. Not only that, but we do not understand the language he uses as a specialist. This continued proliferation of specialties, each with its own language, facilitates interaction between individuals in the same specialty, but for the rest of us it becomes another barrier.

One's occupation is an important aspect of his identity. We place a great deal of emphasis on work as such. We value work, not only for the income it gives us, but also because we believe that to work is better or more moral than not to work. We see on every side exhortations to work, because it is somehow good for us; it is a source of human dignity; a means of praising God. With such public approval it is not surprising that we tend to see it as reflecting our own worth.

> Since a person's self-image, his pride or self-respect, are entwined with his job, it is not surprising to find that there are attempts to develop or maintain a positive public image of an occupation. §

This is done in a number of ways through the process of professionalization. The occupation tries to ensure: that its members receive a prescribed, formal course of academic training, preferably within a university; that they form a professional association; that they formulate a code of ethics and licensing regulations. All of these factors promote a favorable image of the occupation in the eyes of the public. The nursing profession is an example of this trend. This change in the

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§ Jones, F.E.: *An introduction to Sociology*. Toronto: C.B.C., p. 29.

way in which people approach the work they do has some consequences for the relationships between professional groups and their members. Their relationships become more formal and controlled. Sentiment and affection are out of place. This is also true with respect to the professional's dealings with his client. Here we have another example of the increase in the degree of impersonality in human relationships outside the home.

Behind the growth of specialization lies a corpus of knowledge which is augmenting at an increasing rate. As knowledge grows in a particular field new applications are discovered and new specialties arise. This is particularly obvious in medicine and the physical sciences. The high degree of specialization has significant consequences in the sphere of government. The legislature is not chosen on the basis of the specialized knowledge of its members, but increasingly they are faced with the problem of the effects of the application of new knowledge on society. Atomic physics is the obvious example of an area of knowledge which, in its practical application, can have harmful consequences for all of us.

### Rules and Regulations

The legislature is faced with the problem of control, but since its members are not specialists they cannot legislate in detail. They, therefore, lay down a policy that enunciates basic principles, and set up regulatory bodies whose function it is to control the operations of those applying the specialized knowledge. These regulatory bodies, such as Atomic Energy of Canada Limited, the Board of Transport Commissioners, the Canadian Wheat Board, the Board of Broadcast Governors, and many others, are given the power to regulate the special fields. This appears to delegate a great deal of power to bodies that are not answerable to the electorate except through an elected Minister. In some areas the civil service is given regulatory powers. In this way government bureaucracy expands, and, I venture to say, will continue to expand.

The ordinary citizen seems to be hemmed in on every side by individuals who guide, regulate and sometimes punish him for actions that he considers his own business, but which they consider have deleterious effects on society at large. I do not see any solution to this bureaucratic interference with what we consider to be our private actions. In a simpler world, when we were a predominantly agricultural society, we required very little regulation. Now we face the prospect of losing what some conceive to be fundamental freedoms.

## Knowledge and Industry

There is an obvious reciprocal relationship between the growth of knowledge and increased industrialization. The latter requires diffusion of knowledge so that there is a rise in the general educational level of the population. This is easily seen in Canada where, between 1941 and 1951, we saw a rise of from 9 to 12 per cent of the school age section of the population attending university. The rise in the general educational level has had serious consequences in terms of the demand for goods and services. The general ideological conception of what constitutes the good life shows a significant shift. The demand for certain consumer items declines, whereas for others it increases. In addition, new demands arise which, once met, become part of our set of expectations and we are then unwilling to forego them. When governments fulfill some of these demands, they find it almost impossible to relinquish the responsibility. Thus, in the field of education, it is inconceivable that any government would claim that this is not its obligation. Government services are seen as a matter of right. Consider family allowances, old age pensions and unemployment insurance. You will see that once government steps in to provide services or protection against the vicissitudes of modern living, these are quickly seen as rights.

### Public Criticism

Another result of the rise in educational levels is an increasingly critical attitude on the part of the public. Traditional ways are scrutinized and measured against rational norms. More and more people try to apply their cri-

tical faculties to some of our most sacred beliefs and traditional behavior. There emerges a growing demand for new ways of doing things from dietary habits to baby care. For example, the modern housewife is constantly seeking a better dietary balance for her family and the latest methods of feeding and caring for her baby. She, like so many others, has a firm belief in the benefits to be derived from the application of science, or more correctly, the scientific method. She is reminded continually, through mass media, of products and services that are based on so-called scientific findings. Somehow she must make a choice from the welter of claims that bombard her. If she becomes confused, who can blame her?

This belief is shared by the professions whose activities are based on scientific findings. But today, with the emergence of the social sciences, the professions find that their traditional forms of organization, their values, and their web of professional relationships can be examined, dissected and evaluated. The economist looks at what he terms the health industry and evaluates the operations of the market mechanisms. The term "medical economics" is familiar to many. Social scientists may examine the programs that social workers operate to ascertain whether the stated goals of these professionals are, in fact, the end result of their activities. Sometimes we may find that the ends reached are a far cry from the desired ends. Much of human behavior can be evaluated in this fashion. Through the application of strict scientific methods we can show the effects of particular action programs. Take, for example, an evaluation of a health education program or a nursing program. Through the use of experimental and control groups it is possible to determine their effects. The application of these techniques to an evaluation of human action programs is on the increase. The day may not be far distant when we will assess much of our organized activities in this way.

## Family Changes

The social and economic changes already noted are related to changes in family organization. There is no doubt that certain major changes have occurred in our family system. Some of them have resulted in serious disorganization. What we have to decide is whether this disorganization is a chronic state of affairs, or whether it is due to what Professor Parsons has called "the disorganization of transition," due to certain basic structural changes in organization.||

### Divorce Rates

There is some doubt that the present state of affairs is chronic. If we take the United States as an example, it appears that the rise in the divorce rate has been checked and, from a post-war high of just over 18 divorces per 1,000 married population in 1946, it declined to just over 9 per 1,000 in 1956. It is difficult to compare this trend with Canadian data, but it appears that while Canadian figures are consistently lower they rose between 1941 and 1951 to just over 5 divorces per 1,000 marriages. This figure remained about the same until 1956. It is likely that there has been a slight decline since then.

That divorce has not led to a serious disillusionment with the marital state is obvious from data already mentioned. In 1901 nearly 52 per cent of the population was married whereas in 1956 nearly 66 per cent was enjoying this happy state. In the United States, despite the fact that it is easier than ever before for single women to be economically independent, "the proportion of the population married and living with their spouses is the highest that it has ever been in the history of the census and has risen perceptibly within the recent period."||

### Birth Rates

Another factor that points to a process of readjustment rather than a trend towards disorganization, is the rise and subsequent levelling of our birth rate after 1941. Prior to that date, especially in the 1930's there was a steady decline which corresponded with the depression years.

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|| Parsons, T.: The Stability of the American Family System. N.W. Bell and E.F. Vogel (eds.) *The Family*. Toronto: The Macmillan Company, 1960, p. 93-4.

## Family income

The claim is often made that family conflict is engendered to a great extent by poverty. Data on the distribution of families by income group indicate that a greater proportion of families than ever before are earning incomes above subsistence level. In 1951, 35 per cent of families and unattached individuals earned less than $2,500 per year. By 1959 this proportion had dropped to 28 per cent. On the other hand there was a slight rise in the $2,500-$6,999 range, and a substantial rise, from 7.7 to 14.4 per cent, in the $7,000 and over class. ** In other words, these data show that a change in our income structure is occurring so that a greater proportion of people are being pushed into higher income ranges.

## Juvenile Delinquency

As evidence of family disorganization many people point to the increase in juvenile delinquency which, among other things, they attribute to lack of parental control in homes where the mother is working. Lack of parental control is probably an important element in delinquency, but I am not so sure that because the mother works this control is always absent. In a study undertaken by the Gluecks a group of 500 delinquent boys was compared with a group of non-delinquents who were similar in intelligence, ethnic backgrounds, ages and areas of residence. From the study it appears that

> . . .Whether the mother is working or not, the quality of the supervision her child receives is paramount. If the mother remains home but does not keep track of where her child is and what he is doing, he is far more likely to become a delinquent . . . than if he is closely watched. Furthermore, if a mother who works does arrange adequate care for the child in her absence, he is no more likely to be delinquent (indeed, possibly less so!) than the adequately supervised child of a mother who does not work . . . ††

With an increasing proportion of Canadian families in the middle income range, it is possible that the children of working mothers in Canada are given adequate paid supervision. In addition, it appears that a large proportion of these children are supervised by fathers or other relatives. The Children's Bureau of the U.S. Department of Health, Education and Welfare estimates that well over half (58 per cent of children under 12 whose mothers work) are cared for in their own homes, chiefly by fathers or other relatives.§§

I do not want to leave you with the impression that family disorganization is not a serious problem. It is, but it is something that we have to expect in a period when the rate of social change is increasing. My thesis is that the family, like the rest of society of which it is a part, is in a state of transition. No one can tell what the final structure will be.

## Divided Loyalties

There is one obvious problem that working women, especially married working women, face when they enter the work world. I have indicated that because the job comes to mean so much to us we tend to see ourselves as reflected in the work we do. It becomes part of the image of ourselves. This process of self-identification with the job may pose a serious problem for some women for, if they are also wives and mothers, they are expected to identify with home, husband and children. For those wives who work on a temparary basis there is no serious strain in the demands they face at home and at work. After all, they are transients in the work world; they do not intend to remain there indefinitely.

For the professional woman, the problem is more acute. She encounters serious and sometimes insurmountable difficulties in trying to identify with both the professional world and the

** Dominion Bureau of Statistics. *Distribution of Non-Farm Incomes in Canada by Size.* Ottawa: Queen's Printer, 1962.

†† Macoby, E.E.: Effects Upon Children of Their Mothers' Working. N. W. Bell and E.F. Vogel (eds.) *The Family.* Toronto: The Macmillan Company, 1960, p. 522.

§§ Herzog, E.: Children of Worning Mothers. Washington: U.S. Dept. of Health, Education and Welfare, 1960, p. 13.

home. In a sense she has to become a psychological quick change artist. In the office she is the efficient, careful, considerate and somewhat impersonal professional with a reputation and a clientele to maintain. Success in this situation means monetary rewards and the praise and esteem of her professional peers. She views herself through their eyes; what she sees gives her satisfaction. Then she goes home to a family where she must present a completely different face. Instead of the impersonal efficiency of the office she must show love, tenderness and sentiment. If she does not succeed in presenting herself in this way she will incur the disapproval of the family and her self-image will suffer.

### Family Structure

These pressures on family structure must be seen in relation to the isolation of the modern nuclear family. In the past few centuries we have seen the break-up of the extended kinship unit of which the nuclear family, consisting of husband, wife and children, was a part. Surrounding this family was a structure of relatives from both the husband's and wife's families. Some of these relatives could be relied upon for help and support not only in crisis situations, but also in day-to-day activities. Furthermore, this family of a former era had more functions than the modern family. It not only had the reproductive function, but also educational, economic, religious and sometimes political functions. These were shared by the surrounding relatives, the extended family. In our modern society these functions are performed, not by the extended family, but by specialized institutions organized on bases other than kinship. The modern nuclear family's relationship with these institutions has become more important while the relationship with the extended family has become less significant. In this sense the modern family is isolated from surrounding relatives. This is accentuated by the high rate of spatial and social mobility in our society. Families are moved around by the firm, or they move to find work or to seek better work. Families move up the social scale and leave their parents and other relatives below.

In a complex society, beset by serious economic and political changes, man faces a changing environment, especially in the world of work. This world of impersonal norms of efficiency and productivity gives no opportunity for the expression of the emotions that it engenders. A factory cannot be run on the basis of emotional likes and dislikes. Emotions must be held in check, at least until they can be expressed in an appropriate time and place. The time is after work; the place is in the home. The family becomes the emotional spigot for the expression of frustrations engendered elsewhere. The modern family, however, lacks a network of relatives who can provide support at the very time when it is needed to meet this type of pressure. The family is based on the romantic attachment between husband and wife, the very antithesis of the impersonal norms of the world of work. The strain aroused by the release of frustration carried home from work is quite severe. It should be no surprise if we find evidence of family disorganization.

In summary, I want to emphasize that I have presented what might be termed the modal picture of social changes. There are many variations according to the region in which we live, the ethnic or religious group to which we belong, and the social class of which we are members. On the other hand these changes are similar to those now occurring in other modern industrialized countries.

## Social Change and Nursing

The changes portrayed are related intimately to the problems facing the nursing profession today. I do not think that you can fulfil your responsibilities as nurses without first trying to understand the types of changes now taking place, and then tracing their relationship to you as a professional group and as individual nurses with a most important function to perform. Without this knowledge, it seems to me that you would be operating in an unreal word. The time would come when the organization and values of the profession no longer would meet the demands of a changed society. Of the changes described, there are two of particular importance to nursing.

The first is the rise in consumer expectations with its implications of a rising demand for all types of health care. These expectations are based partly on our increased affluence and partly on the example of other countries, notably the United Kingdom and the Scandinavian countries, where the various forms of health care are an accepted part of public planning in terms of the organization of services and their financing.

The second change that will have important consequences for you is the increasing rate of scientific discovery, especially in the field of medical care. As the field of medical knowledge grows, nurses will be expected to encompass that part of it which is the basis of their professional activity. This will require critical assessment of present training systems both in terms of content and organization. These programs must be related to the changing technology of medical care. In other words, the new knowledge must be learned and the new technology applied. This may mean a greater degree of specialization within nursing. It may mean that you will have to relinquish certain of your functions to other technical personnel.

Whatever the future may hold for you, I feel sure that you will thoroughly appraise the implications for nursing in social change. The nursing profession is examining its functions and its relationships with other health professions with a very critical eye. This self-appraisal is a sign of maturity.

# In the Good Old Days

*(The Canadian Nurse* — OCTOBER, 1922)

For the ordinary duties of a private duty nurse, the junior matriculation standing or the senior matriculation ought to suffice, if diligence be used in subsequent private study and self-education. If more ambitious, the years between 18 and 21 might be profitably devoted to science and other preparatory training, combined with a business course including stenography and typewriting, followed by two years in the wards.

* * *

In most callings at the present time, eight hours is considered a working day; but in the hardest of all employment wherein the wear and tear of mind and body from vigil and anxiety is constant and extreme, 12 hours per diem obtains in Toronto and in many places 15 hours night duty. Who is so sanguine as to expect the best results under such conditions? If the nurses are true to themselves *and hold together,* it will be only a short time before reasonable hours of labor are established for them also.

* * *

The available information about vitamins has assumed bulk but is yet subject to much addition or change. The present accepted family consists of A, B, and C and the probable D and E vitamins.

The A group are essential to growth and are found in milk, butter, egg yolk, fat and the green leaves of vegetables. The B group are essential to growth and are anti-neuritic. They are found in yeast, the seeds of plants, peas, beans, cereals, eggs, milk and glandular organs. The C group known as anti-scorbutic, are found in cabbage, turnips, lettuce, watercress, lemons, oranges, raspberries and tomatoes.

Rickets is caused by a deficiency of vitamin A. Cod liver oil, rich in "A," has a remarkable value as a supplementary food.

As children grow up, a wide choice of dietaries decreases the danger of vitamin deficiency. Here the slogan must be "educate." Children are quick and eager to choose vitamin articles of food once they learn about the "mysterious helpers."

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It is in self-limitation that a master first shows himself.

GOETHE

# COMMUNICATIONS

B. J. McGuire

*Good communication is a two-way process. It requires an appreciation of the interests and knowledge of various groups and the ability to communicate with them in terms they will understand.*

The human being, we are taught, is a rational animal. The existence of this power to reason is disclosed by the ability of the human being to communicate thoughts. It may be that other animals communicate, but to what extent is not known. Human beings talk to each other and some of the things they say can be rather shattering, but they communicate on every subject known to the human intelligence.

I would like to make it clear that I am not a nurse, doctor or hospital administrator so I am no expert on your particular problems. But I will anticipate an observation. You will probably say "But our problems are different." Everyone else says that so why shouldn't you? Certainly they are different, but the basic reasons for the problems are not different. These reasons are common to all people because at the root of your problems you come to that standard source of trouble, the human being.

Somewhere in the last half century, it became apparent that institutions, business enterprises and industrial operations had become bigger — so much so in fact that it was no longer possible for the boss to know everybody personally. This led to the conclusion that it was necessary to set up some system of communications to replace the personal contact lost in the growth of the particular enterprise. This sounds logical enough. Almost every type of Canadian organization has become larger within a lifetime. In most instances, the boss can no longer walk through the place and call everybody by name. It seems logical, therefore, that some supplementary form of communication should be established to replace what has been lost. But, what has been lost? In my opinion, nothing. I believe the concept of bigness as a reason for communications holds only enough truth to be expensive, dangerous and disappointing.

For practical purposes in this period of small business, to which we refer with nostalgia, there was little or no communication between employees and their superiors. Generally speaking, employees were told nothing and learned quickly to speak when they were spoken to, and then to speak with tact rather than candor. Thus, the need for communications today does not arise from the increased size of business and institutions. I wish to emphasize this point because as a motivation for increased communications it leads to wasted effort and disillusionment. It fails because it fails to recognize that a good communications system must be a two-way operation.

Communications are an essential part of modern business and human relations. However, if bigness has not created this need, what then accounts for it? Let's look at a few of the things that have happened while these establishments were growing bigger.

Of considerable importance is the fact that educational levels have risen. Some of you may remember when the average industrial operation was carried on by a considerable number of people who could neither read nor write. It was unusual for an hourly-paid employee to have attended high school. In Canada today, adult illiteracy is practically unknown. Educational levels have risen. Furthermore, they will continue to rise. At a meet-

ing in Paris in 1958, UNESCO executives estimated that eventually the normal age for leaving school would be 23-25 years. This estimate was based on a forecast of the industrial and administrative needs of the future.

Since the purpose of education is to enable people to read and study, to stimulate them to question, examine and evaluate, it follows that the higher the level of education the greater the demand for information. Knowledge creates its own appetite for additional knowledge. This factor alone contributes heavily to the need for additional effective communications.

Coinciding with this educational advancement has been a dramatic development in the facilities and speed of communications. First came a crystal set when a peanut-tube radio was a big machine. Since then the telephoto has been developed which flashes news pictures around the world with the speed of electricity. Television has advanced from a novelty to a household institution. And now "Telstar" brings intercontinental programs into our homes. These forms of communications are not only rapid and varied but, like the telephone, are at the disposal of everybody in Canada.

Another thing that has happened has changed our way of life. Some of you from Eastern Canada came west on a jet that took only a few hours. Twenty-five years ago it would have taken several days to cross the continent. Transportation speeded up and created its own impact on communications.

This is not all. The work-week has been reduced gradually from 60 hours to 40 or less. Salaries and wages have gone up. The average weekly wage in industry, according to a recent report, was $80.88. The effect of shorter hours and higher wages has been to create the absolute necessity for higher productivity. Organization, mechanization and automation have helped to make possible higher productivity and greater individual effectiveness. Neither organization nor mechanization nor automation can work effectively without good communications.

Would it be reasonable to assume that people could experience higher educational levels, speedy communications, faster transportation, shorter hours, and higher wages without being affected by them? I do not believe so. That is why it is a mistake to assume that bigness is the reason for the present day need of more effective communications. Bigness has been a factor but it is only one of many. More important is the fact that our whole system of organization and administration has had to be realigned to meet conditions as they exist today.

Communications are an integral part of modern organizations and administrations. You are familiar with the word "organization" and you would all have a definition for it. You are familiar with the phrase "work division" and all understand it. How many of you are familiar with this definition? *Work division is the basis of all organization and the reason for it.* Think this definition over. See if you can tear it apart. I don't think so.

Let us look at the phrase "work division" for a moment. Why and when is work divided? Work must be divided when :

1. There is more work than one person can do;
2. work must be done in more than one place at one time and therefore one person cannot do it;
3. the work to be done requires more skills, talent or experience than any one person possesses.

This is the basis of all work division. Work division in turn is the basis of all organization. Any time that more than one person is required on a job, organization or work division is involved.

It is unnecessary to defend the premise that well-informed, cooperative people are more effective than people working under compulsion. Nor is it necessary to prove that an effective and efficient operation will do more and better work than an inefficient operation. If you accept the fact that well-informed people, who are voluntarily cooperating in their efforts, produce the best results you come face to face with the elementary question of how to have well-informed and cooperative people around. The answer is simple. Tell what you are doing and why, and what they are doing and why. In a word, communicate.

The time has long since passed when people work effectively because someone tells them to. The most dramatic story in this field is the Charge of the Light Brigade at Balaclava, immortalized in verse. It was a sad event in the history of human relations when the finest light-horse brigade of the era was slaughtered because of poor communications. There is just as much loyalty in the world now as there was before. If anything, people are more anxious today to do a job well and effectively than at any time in history. The essential difference is that they want to know *why* they are doing things. There is only one way to satisfy this desire and that is to tell them.

I have not dealt here with the technique of communications but rather the need for them. In the nursing profession there are many areas where additional communications can be helpful, but permit me to say this : if you could satisfy every need for communications in your profession today and you rested on that, within five years it would be out-of-date.

It would be pleasant, indeed, if I could provide a blue-print that would solve communications problems in every area. Unfortunately, I cannot. The best I can do is to suggest a number of guide lines that may be helpful.

Your problems of communications are with people, all kinds of people, nurses, doctors, patients, families of patients, administrators, service people, reporters — in fact the whole spectrum of the population. This is the root of the problem. If there is one thing that is certain in the field of communications, it is this — if you wish to communicate effectively with anyone you must talk in terms of the knowledge and interest of that individual. Obviously, the knowledge and interests of a patient will be different from those of a nurse. The knowledge and interest of a nurse will not be the same as that of a doctor, an administrator or a plumber.

The first requisite of good communications, therefore, is to know your audience. The second is to talk to your audience in terms of its interest and knowledge. Such phrases as "general public" and "average citizen" are clichés in our language. When you examine either you find there is no such thing. There are simply groups of people with common interests. These various groups may comprise the public; they may be professional or non-professional, white-collar or hourly-paid.

I would like to make one observation that it is important for you to remember. Nurses, like any other profession or trade or common interest group, tend to develop their own vocabulary. This vocabulary is, in effect, a form of oral shorthand. Nurses are not alone in this. Every group does it, because it facilitates communications within that particular group. Beyond the group, however, it becomes a foreign language. For example, when nurses speak about "clinical experience" you refer to certain circumstances that are known and understood within your profession. To me and to several million people like me, the expression "clinical experience" means something to do with a medical clinic — perhaps a place where injured people might be taken to "experience" treatment. If you use that phrase to lay persons, it conjures up a picture of something entirely different from what you mean. Thus, remember that when you use expressions peculiar to your profession you are failing to talk to the people beyond it in terms of *their* interest and knowledge. To this extent you are discounting your effort.

What are people interested in? How do you talk to them in terms of their own understanding? What interest do people have in nursing and its allied activities?

On this subject I can say a few encouraging words. People generally are curious. Against any given situation, people have four primary interests and the nature of them may surprise you. In almost any circumstances, people are interested in the following :

1. Does this business, company, institution or person know its job?
2. Is the work or service performed useful?
3. Are the people who are doing it pleasant to know and to deal with? In other words, what is the character of the individual or organization?
4. Is the individual or organization

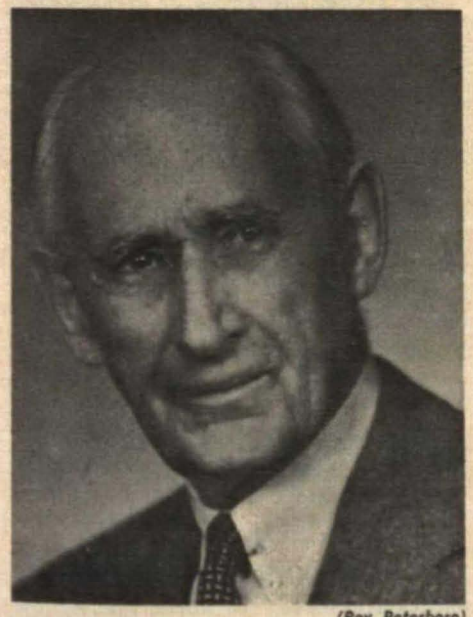
a good community and corporate citizen?

If there is any one profession that can answer all of these questions with a resounding "yes", it is the nursing profession. It meets all of these standards fully and completely. In a democratic world, where we can be effective only with the consent and approval of those with whom we work, the nursing profession has many advantages — provided the channels of communication are open and effective.

# HONORARY MEMBERSHIPS

Three distinguished Canadians from other vocations and careers were awarded honorary memberships in the Canadian Nurses' Association at the Biennial Convention in June. Each one has made a special contribution to nursing in Canada.

In 1927 when the question of a study of Canadian schools of nursing had come to the fore, a respected member of the medical profession, DR. GEORGE STEWART CAMERON, suggested that as a preliminary step, there should be formation of a Joint Committee on Nursing. This committee would bring together representatives of the Canadian Nurses' Association and the Canadian Medical Association. Dr. Cameron felt that, with this group as a basis, other associations could be approached for information and assistance; there could be reciprocal interchange of ideas and plans which would benefit all. The Joint Committee was subsequently developed and Dr. Cameron became its first chairman.



*(Roy, Peterboro)*

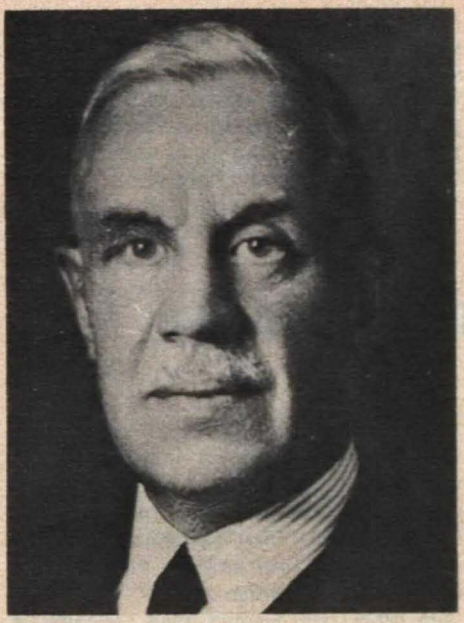
DR. GEORGE S. CAMERON

In 1929, Dr. George Weir, Faculty of Education, University of British Columbia, was appointed to carry out the study of Canadian nursing education. Dr. Cameron, as chairman of the Joint Committee, was responsible for guiding the study. In his foreword to Dr. Weir's report, Dr. Cameron summed up the situation in a brief, direct statement:

> . . . In Canada it was generally agreed that the training of nurses was unsatisfactory, and that something should be done to improve the matter.

Dr. Cameron was born in Ontario and studied medicine at Trinity Medical School, Toronto from which he graduated as the gold medallist of his year. He practised his profession in Peterborough, Ont., and since his retirement has continued to call that city home. Dr. Cameron is a past president and life member of the Ontario Medical Association and a senior member of the Canadian Medical Association. Although convention members regretted his inability to be present for the ceremony, it was with pleasure that honorary membership was conferred upon him, in absentia.

WILLIAM BRIDGES SCOTT, Q.C., Chief Justice of the Superior Court of Quebec, served Canadian nursing well at one of the critical periods in its history. When national incorporation for nurses was being sought in the middle and late 1940's, Chief Justice Scott provided the legal counsel and encouragement sorely needed to offset the failure of



HON. CHIEF JUSTICE W. B. SCOTT

three efforts to secure such legislation. A constitution and Draft bill were prepared in 1946 as a fourth attempt and in 1947 Parliament finally passed the Act of Incorporation. Chief Justice Scott guided the drafting of the Constitution and Charter and presented the successful Bill to Parliament.

A native of the province of Quebec, a graduate of Bishop's University, Lennoxville, P.Q., with a Master of Arts degree and of McGill University as a Bachelor of Civil Law, Chief Justice Scott has had further honors conferred upon him by both Alma Maters. He holds the degree of DCL from Bishop's University and a Doctor of Laws degree from McGill. During World War I, he served with the 14th Battalion, Canadian Expeditionary Force. Appointed to the Superior Court of Quebec in 1952, he became Chief Justice in 1961.

*(Canada Wide Photo)*

MRS. REX EATON

FRAUDENA GILROY EATON is a long-time champion of the causes of women. Born in Nova Scotia, she is a graduate in arts of Acadia University, Wolfville, N. S. and holds an honorary Doctor of Laws from the University of British Columbia. Her services during World War II won for her the honor of being made an officer in the Order of the British Empire.

Mrs. Eaton is a past president of the National Council of Women of Canada; president of the United Nations' Association of Canada; honorary vice-treasurer and chairman of finance of the International Council of Women. When the Canadian Nurses' Association held its first Conference on Nursing in 1957, Mrs. Eaton was one of the keynote speakers.

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The rising popularity of convenience foods has caused the per capita consumption of canned and frozen vegetables to climb steadily in the past decade, at the expense of fresh vegetables. From an average of almost 115 lbs. per person annually in 1950, fresh vegetable consumption dropped to only 99 lbs. this year. Most popular among the fresh variety are those vegetables for which no satisfactory processed substitute may be found: salad greens, tomatoes, celery, onions and corn. Turnips are not yet threatened.

—*Business Week*, Nov. 11, 1961.

The man who does not read good books has no advantage over the man who can't read them.

MARK TWAIN

It is unfortunate, considering that enthusiasm moves the world, that so few enthusiasts can be trusted to speak the truth. —A. J. BALFOUR

# Acceptance Address

The Honorable Chief Justice W. B. Scott

*Chief Justice Scott spoke on behalf of all the lay members who received honorary memberships at the recent Convention.*

On behalf of those who are not nurses, I wish to express our deep appreciation of the signal honor that has been so graciously conferred upon us this afternoon in being awarded an honorary life membership in this distinguished professional national association.

As a layman it is a privilege to have an opportunity of paying public tribute to the registered nurses of Canada at their biennial convention.

It is not generally realized that Canada has been fortunate in having nurses for over 300 years, starting with the ministrations of the religious nursing sisterhoods who came to the new world during the French regime, their first hospital being the Hotel Dieu at Quebec founded in 1639.

Nursing has come a long way since Florence Nightingale, following the Crimean War, organized systematic training for nurses in St. Thomas's Hospital, London. Other hospitals followed suit. Then the advances in medical knowledge in the 1880's, particularly in respect to bacteriology, revolutionized nursing in the home and in the hospital. These discoveries made it imperative for the nurse to be trained in the scientific disciplines.

The contrast between the old days and the present is shown in *The History of the School for Nurses of the Montreal General Hospital* by Dr. H. E. MacDermot. This hospital was founded in 1821.

> For the first 60 years and more there was nothing at all corresponding to our modern ideas of nursing.
>
> Those who actually nursed the patients were quite untrained. They were engaged by the month, and the chief requirement seems to have been that they should be married women. Quite frequently they were chosen from amongst those who had been patients in the wards.
>
> Many of these women however must have had a natural instinct for nursing.

As to wages and meals prior to 1833, the records state:

> The wages of all female servants shall be not more than $5.00 per month, and of the man servants not more than $8.00 per month.
>
> Their diet shall be tea and bread and butter for breakfast and supper, meat and soup for dinner, and 7 gallons of beer a week. Butter not to exceed 6 lbs per week. The matron to be allowed 2 lbs. per week.
>
> Later on they were also given 3 ozs. of tea per week each, and 1 lb. of sugar.
>
> The allowance of beer, however, was subject to change. On September 18, 1833, the Committee of Management ordered that the night nurse be given no more beer, but receive tea instead.

In the Canadian Nurses' Association we now have duly registered lay nurses and registered nurses from the nursing sisterhoods carrying on together from coast to coast. Just as bacteria have no provincial boundaries, so too the work of the nurses has no territorial limitations.

The fact that there is now one strong national association of over 63,000 members, representing the professional nurses of Canada, is due to the sound foundations laid by the early leaders who strove mightily to secure national incorporation for nurses. Three efforts to secure this legislation failed, but the unincorporated association was properly insistent and, after meeting in Toronto in 1946, a constitution and draft Bill were agreed upon. The following year Parliament passed the Act of Incorporation. The present membership is enjoying the benefits of the splendid work of those who secured national incorporation for registered nurses.

In this day and age a world without trained nurses is just as unthinkable as a world without mothers. We know how often the doctor, having done all that medical skill can provide, will say, "Everything now depends on proper nursing care."

Madam President, on behalf of the "non-nurse" group, once again we say thank you for this signal honor and, with all due respect, we salute the Canadian Nurses' Association and its 63,000 members. They have flourished. May they continue to flourish.

Vive les infirmières!

# THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

### *Evaluation — Vancouver Convention*

The final registration figure of the 31st Biennial Meeting held in Vancouver, June 24-29, 1962, was 1412.

On the closing day each registrant was provided with an evaluation form with the request that it be returned to National Office. It was felt that the suggestions of CNA members would be of assistance in the planning for the next convention.

By the end of July, 68 forms had been received. These evaluation reports were read with much interest and studied carefully. Although the individual comments varied from — "I was stimulated and challenged" to "I went away very disappointed," the general opinion was that, on the whole, the convention was a success. If the reports are typical, the best parts of the convention were the addresses of the guest speakers. The most popular were Miss Nussbaum, Doctor Hickman, and Professor Blishen.

The comments on the panels were many and varied. The most popular by far were: "The Royal Commission and the Voice of Nursing" on Friday morning, and "Common Goals of Health Services" on Wednesday morning. Another panel presentation which ranked high in favorable comment was that of Tuesday morning entitled "Nursing Values in a Changing Society."

All aspects of the convention were reviewed from the program to the handling of the press and voting procedure. Several noted the poor coverage given the convention by the Vancouver press and gave helpful suggestions as to how the press might be encouraged. Some regretted the delay in getting sessions underway because of the casualness with which registrants arrived at, or returned to their seats. With respect to the voting there were suggestions as to how this might be streamlined and also the comment was made that "too few carry the voting for too many."

The following is a *sampling of comments:*

Program excellent

Program too concentrated

Program wasn't attractive enough to general membership

Nursing service was in second place

President did a beautiful job — dignity which is expected of our leaders

Liked the luncheons

Topics were of general interest

Leisure time planning excellent

*Suggestions for future conventions* included:

Dominion registration

More opportunity for questions and discussion

Hold sessions 10:00 a.m. to 3:00 p.m., with one half hour for lunch.

Try morning and evening sessions with free afternoons

Hold clinical sessions each dealing with a different area of nursing

Consider forums

More emphasis on community planning, preventive aspects of nursing and health promotion

Give the press summaries of the speeches

Shorten speeches

Start early to get exhibits

The summary of the comments and suggestions will be passed on to the Program Committee for the 1964 Convention in St. John's, Newfoundland.

In the meantime, they provide an opportunity to consider:

*Details of Convention Planning:* The evaluation reports revealed that we of National Office had left members in the dark with respect to the procedure of convention planning. We realize now that members are interested in this detailed planning. This interest is exceedingly encouraging. Procedure with respect to certain details may be of interest:

*The Press* — Briefly, the steps taken to encourage press coverage of CNA conventions are as follows:

1. Quite some time before the convention an advance release is prepared in National Office. This is forwarded to the editors of the local papers in Ottawa, to the Canadian Press, and to national hook-ups of radio and television. Also, as nurses register, this release is forwarded to local newspapers with the names of nurses in that particular community who have registered for the convention. Depending on the news volume this may be published in the paper, not infrequently with the picture of the nurse who will be going to the CNA convention.

2. Shortly before the convention *Press Kits* are prepared. These Kits contain a copy of the Program, biographical data of officers and speakers, copies of speeches if available, folio of reports, and additional pamphlets or statements such as the CNA Platform which will serve as background information. These Press Kits are sent out to the editors of daily newspapers in the major cities across the country, and again to the Canadian Press and national hook-ups. A supply of Press Kits is also taken to the convention and is part of the material in the Press Room. The Kits are available to the local reporters attending the convention.

3. In addition to the advance release and the Press Kits our Public Relations Counsel prepares releases on the main addresses and reports. These releases are available to the Press at appropriate times during the convention. For example, at the very time that the President is delivering her Presidential Address, copies of her address, a press release on it, and matts of her photograph are available to the Press in the Press Room.

During all this time National Office staff confers with the CNA Public Relations Counsel who provides guidance in the over-all public relations program. During convention week he is in attendance to advise the representatives of the press; to arrange press, radio and television interviews; and, most important, to advise National Office staff with respect to the handling of difficult public relations problems or adverse publicity.

Perhaps this is the place to include a word regarding the things that affect press, radio and TV coverage. Generally speaking, press coverage is better in smaller centres. In the large cities the volume of news is much greater and, invariably the sensational makes the headlines. Another important factor is the policy of the newspapers. Some are interested mainly, if not wholly, in controversial matters. Consequently, straightforward factual recording of a convention session meets with little interest. Another factor is the news volume. During the 1962 convention, very burning issues were before the Canadian public:

The election results and their effects on all aspects of Canadian life.

The additional tax on certain commodities and the austerity program.

Lastly, and possibly most decisive, at this particular time Saskatchewan's "Medicare" program was well to the fore in all news channels. Consequently, little space was left in the allocation for other health items.

*The Exhibits* — Some nurses felt we should have had more exhibitors at the Vancouver meeting. The comment was made that certain well established firms apparently were not invited.

It might be helpful to point out that in exhibit arrangements National Office works with and through the Medical Exhibitors Association of Canada. Every firm belonging to MEA receives the CNA Exhibit Prospectus about ten months before the convention. For various reasons some firms find it impossible to attend every CNA meeting. The actual decision is made at the head office of the firm. Some local representatives may have interpreted their firm's decision as a failure of CNA to extend the invitation.

*Voting Procedures* — Because there is, apparently, considerable misunder-

standing regarding how the number of voting delegates is determined and their functions during CNA conventions, a short item discussing these procedures appears elsewhere in this issue.

### *New CNA Publication*

The booklet "Continuing Care," prepared by a sub-committee of the Committee on Nursing Service is mainly for nurses but will also be of value to all personnel concerned with health, sickness and rehabilitation of Canadian people. It was prepared:

> To help nurses become more aware of community resources, their value and availability to patients and their families.
>
> To give some guidance as to how these resources might be utilized and how they might become an integral part of the total care of the patient.
>
> To illustrate the way in which a manual of community resources may be set up and maintained in areas where a directory is not available.

Nursing care is concerned with a person's past and future, as well as the present. It reaches out to cooperate with other groups in the community which contribute to health and well-being. This booklet describes, in general outline, how this cooperative endeavor can be undertaken. Available from National Office in French and English at $.50 per copy.

### *Flash Notes*

HELEN K. MUSSALLEM has returned to National Office, having completed her studies toward a Doctor of Education at Columbia University. Congratulations Dr. Mussallem!

While other staff members in CNA National Office were making vacation plans, JUSTINE DELMOTTE, bilingual nurse secretary, was preparing to leave on a three-month assignment with WHO in Africa. On loan from CNA, Miss Delmotte is assisting WHO in the establishment of a post-basic nursing education program for French-language students. The new school will be located in Senegal.

A new Ph.D. program for nurses has been announced by Boston University Graduate School. The Graduate School and School of Nursing have planned a program for graduate study in Anthropology, Biology, Psychology or Sociology. Miss LUCILLE SOMMERMEYER, Coordinator for Ph.D. Programs for Nurses, Boston University, 264 Bay State Road, Boston 15, Massachusetts will provide full details concerning the program.

World of Nursing, November 1962, will feature Convention Press Coverage in Canada, from east to west.

## DELEGATES AND VOTES

At the annual conventions of most of the provincial nurses' associations, every active member has the right to move, second and vote on all matters of business that are presented. A different pattern has been evolved in both the ICN and the CNA in order to prevent a country or a province with a large membership from swamping the votes of the smaller, less populous areas.

Before a quadrennial congress of the International Council of Nurses convenes, every member country has the right to name five delegates, each of whom carries one vote. In some instances, only one representative from the smaller countries may be present at the congress. In that event, one person will carry all five votes for her country. These voting delegates constitute the Grand Council of the ICN.

Many years ago, the Canadian Nurses' Association recognized that there was a marked disproportion between the probable number of nurses who would attend each national convention from, for example, Prince Edward Island and Ontario. Instead of permitting every member attending a convention to cast a vote, either on matters of policy or for the election of officers, provision was made for voting delegates. By-law VI (page 15) of the Act of Incorporation and By-laws of the Canadian Nurses' Association indicates the way in which the number of voting delegates from each provincial association is decided.

*Section 2*

Each provincial association shall be entitled to appoint three voting delegates in respect of its first fifty (50) members or any part thereof; plus one additional voting delegate for any members over fifty (50) members up to and including one hundred (100) members; plus one further additional voting delegate in respect to any members to excess of one hundred (100) members and up to and including three hundred (300) members; plus one further additional voting delegate for every three hundred (300) additional members or any part thereof if the total membership of such provincial association exceeds three hundred (300) members.

The number used in those rather complex calculations is based on the actual membership of each provincial nurses' association as at December 31st of the year immediately preceding the year the convention is held. Thus, as the total membership increases so does the number of voting delegates. Last December, there were 63,822 members of the Canadian Nurses' Association, of whom 56,523 were active, 7299 associate. Since the above pattern applies to active members only, there were 223 voting delegates. The number from each province was noted on page 786 in last month's issue.

According to that same By-law, each provincial nurses' association is required to file a certified list of the members who have been appointed as voting delegates *before the convention opens.* That may present some problems. Unless the provincial association is prepared to ensure the attendance of its entire roster of voting delegates perhaps by paying their expenses, it frequently happens that a portion of the votes are assigned to specific members with the remainder entrusted to the president. Or, each voting delegate may be assigned two votes or three, as the case may be.

When a vote is being counted by the scrutineers and, in particular, when the ballots are being cast in the elections, it is imperative that each voting delegate should have been informed by the association she represents regarding how many votes she is responsible for. Seldom is this decision left to the group of delegates themselves.

# *In Memoriam*

**Alice (Hall) Anderson** (Hospital for Sick Children, Toronto '34) died in Ramsay, New Jersey after a long illness.

* * *

**Frances Teresa (McAuliffe) Brown** (Hotel Dieu Hospital, Kingston '52) died in Yorkton, Sask., on June 15, 1962. She was on the staff of the Yorkton Union Auxiliary Hospital.

* * *

The alumnae association of St. Joseph's School of Nursing, Victoria, pays tribute to the memory of **Elizabeth Rosine (Schoonover) Bryant** '12 and **Edith (O'Brien) Jones** '29.

The alumnae association of St. Michael's Hospital, Toronto, regretfully records the death of the following graduates: **Lucy Campbell** '22; **Ellen (Perry) Dorr** '16; **Mary (Martin) Moynihan** '47.

* * *

The alumnae association of The Montreal General Hospital pays tribute to the memory of **Ethel Clark** '11 and **Mary McDougall** '05.

* * *

**Rebecca (Watson) Jones** (St. Luke's General Hospital, Ottawa) died recently in Toronto following a long illness. She had served as a nursing sister during World War I and had devoted her professional career to private nursing.

* * *

**Evelyn Judge** (Misericordia Hospital, Winnipeg '25) died some months ago.

* * *

**Eleanor (Floyd) Penfield** (Saint John General Hospital, N.B. '10) died in Montreal on May 11, 1962. She had served overseas during World War I and, for many years, was active in child welfare work in Montreal.

* * *

**Helen Marie (Bagnell) Robertson** (Halifax Infirmary, N.S. '52) died in St. Boniface General Hospital, Manitoba, on July 6, 1962.

* * *

**Reta Louise Sutcliffe** (Hospital for Sick Children, Toronto '17) died in Toronto on June 19, 1962.

* * *

**Bethia Maude Tweedy** (P.E.I. Hospital, Charlottetown '24) died in Charlottetown on June 17, 1962. She was the assistant director of nursing service on the staff of her hospital at the time of her death.

# A LONG LOOK AHEAD

KATHERINE MACLAGGAN, M.A.

*This is an excerpt from Miss MacLaggan's lengthy report to the recent CNA Convention.*

DURING the February, 1961 meeting of the Executive Committee, Canadian Nurses' Association, a new committee, called the Committee on Nursing Affairs, was created. Its term of reference was:

To recommend to the Executive Committee goals in terms of time and subject, such goals to be within the framework and function of the Canadian Nurses' Association.

The first meeting of the Committee was held in November 1961. The first two days witnessed the formulation of statements that could be recommended to the Executive Committee. The third day was devoted to the sharing of these statements with representatives from provincial and national associations. The statements, as supported by the Executive Committee, February 1962, follow :

## 1. All nursing education should be under the jurisdiction of institutions whose primary purpose is education.

*Definitions :*

a. "All nursing education" refers to the education of nurses who meet the standards of admission to organized nursing.

b. "The standards of admission" are defined in each province.

c. The education of the nurse is at the post-high school level.

d. "Educational institutions" are those recognized by the official provincial educational authority.

*Implications :*

a. It is the responsibility of the organized profession to control the standards of nursing education and practice through its Acts and By-laws.

b. Schools of nursing now under the control of service agencies should be placed under the control of the appropriate educational authority in each province.

c. A pattern of replacement for the present service-centred schools must be found.

d. Further capital investment should not be made in service-centred or service-controlled nursing education programs.

e. Capital investment from the public treasury should be made in all nursing education programs under the jurisdiction of educational institutions.

## II. Nursing services must meet the nursing needs of society.

*Implications :*

a. A health service concerns itself with the physical, mental and social well-being of the individual.

b. Nursing services should be available to health service institutions, including

- hospitals of all types
- outpatient facilities
- institutions for rehabilitation and convalescent care
- institutions for long-term illness, including geriatrics
- home care, including nursing homes
- public health services
- such other health institutions as may be evolved.

c. Nursing has the responsibility to evaluate the quality of the service needed and provided, and to adjust this service to changing individual or social needs.

d. Nursing has the right to define its functions to society.

e. Practitioners must possess a legally stated minimum body of knowledge in order to give the defined service.

f. Nursing service needs can best be met through fewer, possibly two groups which can be differentiated on the basis of functions. Having differentiated their functions, the education of each group must be developed accordingly.

III. Financial impediments to nursing education should be removed.

*Implications:*

a. Society can no longer expect that students of nursing will subsidize the cost of nursing education through their service.

b. Nursing education will cost money.

c. The financing of nursing education should reflect acceptable methods used in the financing of education.

IV. Any endeavor requiring able people must offer leadership positions.

*Implications:*

a. Self-government and self-direction are the right and the responsibility of the profession.

b. All other things being equal, nurses should be able to occupy top executive positions.

c. Nurses should have recognition and authority commensurate with their responsibilities.

d. Graduate programs in universities should develop rapidly to prepare nurses in administration, teaching, clinical specialties, consultation, research.

V. Acquisition of new knowledge is essential to a profession serving a dynamic society.

*Implications:*

a. Research and experimentation should be carried on in relation to patient care.

b. Research and experimentation should be carried on in relation to the administration of nursing service.

c. Experimental programs in nursing education should be set up to determine how nursing education should be developed to meet the needs of society.

VI. The value which society places on a given service should be reflected in the income received for that service.

*Implications:*

a. Nurses are entitled to just remuneration and should not be expected to subsidize any health program through their services.

b. Organized nursing has the responsibility to exert reasonable control over remuneration, conditions of work, job security and tenure.

c. Retirement plans with costs shared by employer and employee should be available to all. (Support CNA plan.) Retirement plans should be portable.

VII. The structuring of education and employment in our culture should take into account the biological role of women.

*Implications:*

a. Many of our nurses will be married women.

b. Entrance (or re-entrance) into nursing should be possible following the rearing of the family.

c. Employment practices should encourage married women to work in nursing.


*Coming!*

in

NOVEMBER 1962

Series on Pediatrics
including

Blood disorders
Urological conditions
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Feeding problems

plus additional material

# Nursing Congress for the Americas

HELEN G. MCARTHUR, M.A.

*This Congress was held in Panama, May 1962. It formed the topic for discussion at the special Convention luncheon for public health nurses.*

IT was eight years ago that Pearl Stiver and I attended a Nursing Congress for the Americas in Brazil. As official delegates to the ICN Congress in Rio de Janeiro we were permitted to attend as observers. Representation at that time was in the hands of governments and Canada had not officially aligned itself with the Americas, but rather had preferred to maintain an independent direct line to the United Nations and the World Health Organization. As I remember it, this was a delightful but uncomfortable experience. Although I had had one trip to Europe at that time, this was really my first experience of being cut off by language. At the same time I had to be certain of what was said or what I said, recognizing that I was not functioning as an individual but would be evaluated in terms of the Canadian nursing profession as a whole. They were glad to see us, rather pathetically so, since it was hard for them to understand why Canada stood aloof in the Americas. They tried to make us feel at home in a Latin atmosphere quite foreign to me. I remember the delightful young nurse from Argentine who whispered translations in my ear during the discussion groups in an attempt to keep me in the picture.

HELEN MCARTHUR

The nursing profession in the South Americas was just emerging — turned to the North Americans for the leadership they were certain was there. There was a seed of evidence that the South American nurses knew that there must be a better way but the magnitude of their problems was frustrating and at times depressing.

In May 1962, I returned to a congress of nurses of the same countries but this time held in Panama and with a great difference. Certainly I had changed. In the interim I had learned to feel more comfortable in another culture, another language (to communicate with hands and eyes even though the tongue was silenced by ignorance). However, I was appalled at my lack of knowledge of the South American countries and asked myself "why" many times during the week. I do not consider myself completely uninformed regarding current world events but soon recognized that I knew more about Africa than I did of this vast Continent in the hemisphere in which I live. I was reminded of the story of a Texas barman who noted that his only customers — two cowboys — were each standing alone. Wanting to maintain a reputation for a "friendly atmosphere" he asked them if they knew each other. After a pause one said, "Wal, we've howdied but we ain't shook."

In 1953 I had "howdied" in South

America. In 1962 I hoped to prove myself and clasp the hands of representatives of the 17 countries in attendance. There were some 490 nurses present. All were quite happy in the Spanish language except the majority of the representatives from the United States of America and the lone representative from Canada.

There were a variety of factors that made life easier for me this time :

1. Simultaneous translations at the plenary sessions were good except on one occasion when Lucy Germain (carrying the American Nurses' Association vote) and I, (with the Canadian Nurses' Association vote) lost the trend. Recognizing that the recommendation only concerned South America, we abstained (for the first time in my life, I think, at a nurses' meeting).

2. In the group discussions I expected to have a rough time but they surprised me with one of my own students from the University of Alberta, Miss Margaret Cammaert, who has been working in El Salvador and who was assigned as my personal interpreter. What a grand time we had!

3. I not only represented the Canadian Nurses' Association but was an international observer as the chairman of the Nursing Advisory Committee of the League of Red Cross Societies. The Red Cross, an international symbol now representing 87 countries, provided a ready point of contact, much hospitality and many supports. (They couldn't do anything about the heat for this poor northerner but they did provide a car and chauffeur to see that she could stay out of the sun and use little or no energy!) A special audience at the Presidential residence to be received by Senora Cecilia de Chiari, wife of the President of the Republic of Panama and Honorary President of the Panamanian Red Cross is an example of the kinds of entertainment provided for the international Red Cross observer.

4. In addition to meeting again some of the South American nurses who had been present in Brazil, I was constantly contacted by nursing leaders from South America who would start the conversation with "I attended the University of Toronto." The number of nurses with this background who were selected to attend as the official delegates was a joy and a revelation to me. Through the University of Toronto, Canadian nursing has more than a hand-shaking acquaintance in that part of the world. The influence has been great.

5. Finally, this Congress for the Americas was held in a new atmosphere. This was the first time that such a congress was carried out under the direct responsibility of the National Nurses' Association of the host country, Panama, and the first time that the vote was carried only by the official delegate of the Nurses' Associations of the countries (and not by government appointed representatives as in the past). It took little time to recognize the confidence, the strength and determination of the nursing profession in these countries and their joy in their new strength to stand on their own feet and take the initiative in their own development.

What of the content of the conference? The theme was "The Study of the Needs and Resources of Nursing in our Countries." The why and how were fully explored in group and general sessions. Chile, Brazil and Panama reported on studies made in their countries which were most impressive. The groups worked through objectives, methods and data required. The conclusions in summary, indicated the necessity for the organized nursing profession to take the initiative to start and study nursing needs and resources and to interest their governments in providing the facilities required. Also, that such studies should be carried out by national nurses specially trained in research, advised by other persons experienced in various fields, in collaboration with national and international organizations.

We in North America must look to our laurels. I have a feeling that the nurses of South America are on the march.

I wish I had time to tell of the color such as the fiesta night with all in national costume — (I felt so dull and pale and stiff beside the beauty of the South American women in national costume doing native dances!); of the President of the Republic opening the Congress accompanied by a most impressive armed guard; of the food, the heat, the flowers, the songs, but go see for yourself — the next Congress of the inter-Americas will be in Colombia in 1964.

# CORRELATION–A NEW DIMENSION

BERNARDINE STRIEGEL

*Talk given at the Occupational Health Nursing luncheon at the CNA Convention in Vancouver.*

SINCE occupational health as a specialty is relatively new, we occupational health nurses have been concerned with defining our own functions, qualifications, and personnel practices as well as our place in the total nursing structure. We also have been exploring how basic and postgraduate nursing education can prepare the nurse for occupational health practice and how the nurse on the job can enrich her background through workshops, conferences, and other means.

We can be proud of our formal statements of occupational health nurse practice. For instance, here in Canada, the "Guide for the Preparation of a Manual of Policy and Procedure for Occupational Health Nursing" was prepared by National Health and Welfare; "Functions of the Occupational Health Nurse" was prepared by the Registered Nurses' Association of Ontario; "Duties and Responsibilities of the Occupational Health Nurse" was prepared by the British Columbia occupational health nurses. We can be equally proud of our research, our workshops and conferences, our magazines and newsletters, our interpretation of occupational health nursing to our own and other professions, and our good beginnings in integrating occupational health nursing concepts in the nursing curriculum.

While *we* have been concentrating on occupational health nursing activities, the full-time and part-time physicians in occupational health practice have been concerned with their scope, objectives, functions, preparation and the place of occupational health in the medical profession and in medical education. They, too, have prepared materials and have a specialty status in the medical profession. An excellent Canadian example is "Guiding Principles for the Provision of Occupational Health Services."

Management groups also are increasingly aware of the basic responsibility of the employer to protect the employees against any adverse job-connected conditions. They realize that the maintenance of a high level of employee health is not only an integral part of sound personnel practice and good human relationships but also has economic and public relations value. It affects health, morale, production and the status of the company in the community. Management groups have put this belief in writing; they discuss it at meetings and include the maintenance of employee health in courses in schools of business administration.

What has been said about occupational health physicians, nurses and management, can be said also about industrial hygienists, safety engineers and others who share the responsibility for maintaining and promoting employee health.

The very fact that occupational health is a recognized specialty in the medical, nursing and other professions, and that employee health programs have expanded in number and scope, is concrete evidence of the progress that has been made. All this commendable progress fortifies us as individuals and as specialty groups. If we look carefully, however, we see that to date each group has been concerned primarily and perhaps necessarily with its own members. It is true that on a national level in the United States occupational health nursing has a Management Advisory Committee and a Medical Advisory Committee and each committee has a written statement of

relationships. It is true that the Council on Occupational Health of the American Medical Association has nurses on its Nursing and Small Plant Committees, and among other things, it has published "Guiding Principles and Procedures for Industrial Nurses" and "The Legal Scope of Industrial Nursing Practice."

But is this enough? Are we really working together as closely as we might? Do we really understand and accept each other? Do we really see our activities in relation to the related activities of all who share the responsibility for employee health?

Having assessed and defined our own scope, responsibilities and functions, and having prepared our joint statements on relationships, we — management, physicians, nurses and all others who share the responsibility for maintaining employee health — need to look more carefully at each other. We need to understand and accept our differences in background, interest, responsibility and objectives. We need to understand and accept the differences in our related roles in an employee health program.

What are these differences?

Management is well-grounded in the field of industrial organization and is concerned with production, processes, materials, so as to produce goods or provide services. It defines and implements company policies and programs. It is responsible to employees, boards of directors, stockholders and the public which uses its products and services. Its primary concern with the employee's well-being is related to his contribution to the success of the business; management wants to place the right worker in the right job. It wants to keep him healthy, happy, and producing on that job as effectively as possible. Management may never have been concerned, however, with the legal and ethical aspects of medical and nursing practice until an employee health program was established.

The physician knows the curative and preventive aspects of the practice of medicine and the availability of medical and related services in the community. Even if he has not had previous experience or preparation in occupational health, he has been taking care of breadwinners with occupational injuries and diseases. He knows Workmen's Compensation and related laws. On the other hand, his knowledge and experience in business administration may be limited. Although he has a general knowledge of potentially injurious processes and materials, he may not have full understanding of the occupational hazards of this particular company.

The nurse is skilled in nursing care and treatment under medical direction, and in recording and reporting. She may also be versed in health education and counselling. She is the authority on nursing practice, gives leadership in nursing activities, and maintains accepted professional standards within the Nurse Practice Act. On the other hand, the nurse may have little knowledge of job demands, selective placement, employee benefits, occupational hazards, toxic materials or processes and Workmen's Compensation.

We see then that we — management, the physician, the nurse and others who share the responsibility for employee health — bring to the employee health program not only our individual skills and understandings of our roles, but also our differences in interest, background, responsibilities and objectives. Within this framework of differences, we need to forge a unified program that has the common goal of employee well-being. This unification can take place when we accept the fact that maintenance of employee health is a shared responsibility, and when we knowingly collaborate and cooperate with each other. To do this, we first should see if the responsibilities which each specialty group is recommending primarily to its own members, are practical, workable, and related in day-by-day experience where we work together.

One effective way to see our responsibilities in relation to the responsibilities of others for the same function, is to list our recommended activities by function in parallel columns and then correlate them horizontally. This is what we did in our new publication, "Correlated Activities in an Employee Health Program."

Our parallel columns look like this.

*(Please turn the page.)*

## 1. ADMINISTRATION

| A. MANAGEMENT | B. PHYSICIAN | C. NURSE |
|---|---|---|
| 1. Recognizes:<br>a. the maintenance of a high level of employee health is an integral part of sound personnel practice and good human relations.<br>b. the economic value of a well-conducted employee health program, etc. | 1. Knows:<br>a. the fundamental principles and practices of occupational health, etc.<br>b. the basic principles of business administration, etc. | 1. Knows:<br>a. approved occupational health nursing principles, practices and procedures.<br>b. principles of business organization and administration, etc. |
| 2. Objectives, Functions, Administrative Policies<br>In collaboration with the physician, nurse, legal counsel and, possibly, outside consultants:<br>a. Formulates a written statement of objectives of their employee health service program.<br>b. Defines:<br>(1) the list of functions which the company is willing to undertake.<br>(2) the place of the employee health service in the total company organization.<br>(3) company administrative policies under which the employee health service program will function. | 2. Objectives, Functions, Administrative Policies<br>In collaboration with management, nurse, legal counsel and others:<br>a. Recommends objectives for the employee health service program.<br>b. Recommends:<br>(1) the functions which would be consistent with company objectives, etc.<br>(2) the place of the employee health service in the total company organization.<br>(3) the content and implementation of company administrative policies under which the employee health service will function. | 2. Objectives, Functions, Administrative Policies<br>In collaboration with management, physician, legal counsel and others:<br>a. Participates in formulation of objectives for the employee health service program.<br>b. Recommends:<br>(1) nursing functions which would be consistent with company objectives etc.<br>(2) the place of the employee health service in the total company organization.<br>(3) the content of company administrative policies under which the employee health service will function and interprets nursing implications. |

As we read each column perpendicularly, we see the outlined step-by-step responsibilities of management in one column, of the physician in another column, and of the nurse in another column. Much of this information is not new to us, although bringing it together in parallel columns may be a new technique.

Having done this, we now look at these activities in relation to each other. We correlate them. To do this we read horizontally. The activity of the nurse is matched with the activity of the physician and management, and sometimes others, for the same function. In this process, something happens. We see not only three related activities but also their *interrelatedness* and their *interdependence*. With this insight, we recognize the relationship of our own responsibilities to the responsibilities of the others for the same function. Our nursing activities become a part of a whole and, in this perspective, take on a new dimension. Not only do we see our nursing goal for employee well-being, we see the common goal and we work together toward it.

Let me give you a couple of examples from the function of administration. As we look at the first item, we see that management's basic responsibility in the administration of an employee health program is to recognize that the maintenance of a high level of employee health is an integral part of sound personnel practice: that it has economic, human relations and public relations values.

The correlated basic responsibility of the physician is to know and interpret the fundamental principles and practices of occupational health. He must see their place and value in busi-

ness organizations and in the community.

The correlated basic responsibility of the nurse is to know and to interpret the fundamental principles and practices of occupational health nursing. She must know how they fit into an employee health service program and into business organization and administration.

Each of these individual responsibilities is important and necessary. When placed side by side, notice the added dimension. You see, for instance, that it is not enough for the nurse to know and interpret the fundamental principles, practices and procedures of occupational health nursing. She must see how they fit into the entire practice of occupational health, and into management's responsibility for maintaining employee health.

Another administration example can be found in Item 2, Objectives, Functions and Administrative Policies. In this area, the three branches of the employee health service, and possibly the legal counsel and outside consultants, collaborate in the formulation of a written statement of objectives. Based upon these objectives, they define the scope of health services which the company is willing to undertake; the place of the employee health service in the total company organization; and the company administrative policies under which the employee health program will function. The physician recommends the objectives. He then suggests the functions that are consistent with these objectives, bearing in mind employee needs, existing legislation, standards established by the medical profession and the availability of community medical services. He also recommends the place of the employee health service in the company organization as well as the administrative policies under which the employee health service should function.

The correlated responsibilities of the nurse are to participate in determining the objectives; to recommend nursing functions that are consistent with the standards established by the nursing profession; and to interpret nursing implications of company administrative policies for the program.

The correlated responsibilities of management in this activity are to consider the recommendations of the physician and the nurse and then, in collaboration with them and others, to formulate a basic statement of objectives. From this, the scope of the employee health program activities, the place of the program in the total company organization and the company administrative policies can be defined and implemented.

As a result of correlating this item, the nurse sees the scope and place of her nursing activities in relation to standards established by the medical profession and in relation to the company's objectives for the employee health service program.

We see then that we have an *added* dimension in occupational health practice when the responsibilities of management, the physician, the nurse and others are defined and correlated by function. If we were to follow the correlations through all of the functions, we would see that management, the physician and the nurse have responsibilities for *every* function. These responsibilities not only are related, they are interrelated and interdependent.

When we understand and accept this concept of correlation, we see :

1. That we have a new guide for management, the physician, the nurse and others when a new employee heath program is to be established. It answers questions, such as : "What services should be provided in an employee health program?" "Who should perform them?" "What are management responsibilities?" "What does the physician do?" "The nurse?" "How do we work together?" The wide scope of activities underscores the need for careful selection of a professional staff with the ability and training to carry out these medical and nursing responsibilities. By the same token, it places over-all policy decision-making upon management and indicates the importance of assigning the company responsibilities to a top-level member of management.

2. That we have a new yardstick to evaluate an existing program. Correlated activities in an employee health program can suggest new or different activities. It can provide documentary support to bolster a recommendation or to show the potential

scope of an employee health program. It can support the nurse in relinquishing medical and management responsibilities that may have been thrust upon her or that she may have gradually acquired.

3. That we have a new way to show students of medicine, nursing and management what is involved in this aspect of occupational health practice. It can help them to learn about individual and related activities that are uniquely a part of employee health programs.

4. That we have a new resource for workshops, conferences and in-service education programs. From this total statement, participants can select their individual problem areas and ask for discussion and assistance. The program director can use this as a reference or show how one aspect fits into a total program. Finally, in all four areas, it helps us to focus on our common goal — the well-being of the employee.

Can you imagine the impact if we used this new tool in these various ways? We, as professional and management groups, would work together to better understand each other and to find ways to collaborate and cooperate. We would integrate this concept into our current literature and education, and put it into day-to-day practice.

All these suggested uses for this new statement on correlation remind me of the wag who said, "After all is said and done, there is more said than done."

We know that each group concerned with occupational health practice has defined its scope, objectives and functions. And this is a tremendous accomplishment! In the new publication, Correlated Activities in an Employee Health Program, these various definitions have been placed side by side and our responsibilities have been correlated. Now that we have *said* this much, our next step, perhaps a giant step, is to *do* something about this new dimension — *correlation*.

# Electrolysis: a Therapeutic Innovation

ETHEL M. HEATHE

*Why should a hospital have a department of electrolysis?*

Electrolysis is used as a treatment for hypertrichosis or hirsuitism. It is the removal of superfluous hair from the human body, by the use of a low-frequency, direct galvanic current.

The treatment is slow, exacting and requires infinite patience. The patient needs a quiet, relaxed atmosphere in order to cooperate to the best of her ability. It has been my experience that better results are obtained when the treatment is given by a graduate nurse in the hospital. The patient seems to have more confidence in the treatment.

The departments of dermatology, metabolism, endocrinology, psychiatry, plastic surgery and gynecology all recommend electrolysis. The majority of our large number of patients needs a series of treatments. On arrival the patients are worried; many of them are depressed. The condition causes an unhealthy mental attitude, a marked degree of self-consciousness, a strong inclination to introversion, a fear of ridicule, a lack of femininity and a sense of uncleanliness and embarrassment.

The beneficial results following the series of treatments are really marked. The patient has a smooth clear skin and total disappearance of the disfiguring, embarrassing, unwanted hairs. Her mental attitude has improved. She has more confidence. In short, she has regained her poise, is able to face the world with head high. In many cases it means a better position.

One very important thing for these patients to remember is that the treatments do not provide a complete cure. The origin of the trouble is glandular,

although the glands are not necessarily diseased; frequently it is an inherited tendancy. The hospital's researchers are working continuously, delving deeper and deeper into the function and correlation of the ductless glands. To the present time nothing has been found that is as effective as electrolysis. The patients are advised to come back when necessary perhaps once in 6 months, and never to let the growth increase.

This is not a beauty treatment but one that is of great therapeutic value to the patient. I wish to emphasize the need for an electrolysis department in every large hospital across Canada. We have had patients from every province and many from the United States. They have found it almost impossible to obtain good results elsewhere.

# About Books

**A Mathematical Guide to Dosage and Solutions** by Alice C. Cook, M.Ed., R.N. and Katherine D. Macaw, B.S., R.N. 237 pages. Canada: McAinsh and Company Limited, 1251 Yonge St., Toronto. U.S.A.: W. B. Saunders Company, Philadelphia. Ed. 2. 1962.

The application of mathematics in the field of nursing poses a difficult problem for many. This text was designed to help the student in this practical application. Fractions, decimals, per cent, ratios and proportions are defined, explained and applied to the problems in the preparation of medications that she is likely to encounter.

This is a student workbook with exercises to provide practice in the solution of problems. Sufficient space is allotted on the page beside each problem to permit her to record her solution to the problem.

**American Drug Index** prepared by Charles O. Wilson, Ph.D. and Tony Everett Jones, Ph.D. 840 pages. J.B. Lippincott Company, 4865 Western Ave., Montreal. 1962.

A most useful publication for nurses, doctors, pharmacists and others in attempting to keep abreast of the bewildering variety of drugs and drug products.

The listing is alphabetical with extensive cross-reference so that preparations may be checked under generic or nonproprietary names or under brand names. The name of the manufacturer follows the specialty or brand name. The composition of the product, forms in which it is available, uses and dosage are included as well.

It is interesting to note that the system of cross-indexing permits the reader to find a drug combination in cases where only one major ingredient is known. The specialty name of the drug combination will be found listed below the name of either ingredient.

The final pages of the text are given over to a listing of American pharmaceutical manufacturers and their addresses.

**The Psychological Care of the Child in Hospital** by Agatha H. Bowley, Ph.D., F.B.Psy.S. 47 pages. The Macmillan Company of Canada, 70 Bond St., Toronto. 1961.

"If problems arising from unhappy hospital experience can be reduced to a minimum by careful attention to the emotional needs of the young patient, then it is important to provide as much education as possible concerning the psychological care of sick children."

In this little booklet, there is recognition of the fact that the child's emotional reaction to hospitalization will have a direct effect on his progress. The author suggests the factors that should be considered in helping the child accept the experience. An appendix discusses the care of the handicapped child in hospital.

**Laboratory Manual of Chemistry** by L. Jean Bogert, Ph.D. 296 pages. Canada: McAinsh and Company Limited, 1251 Yonge St., Toronto 7. U.S.A.: W. B. Saunders, Philadelphia. Ed. 6. 1961. This manual was designed to correlate with and illustrate the subject matter

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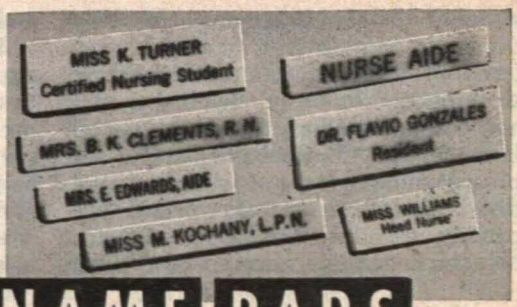


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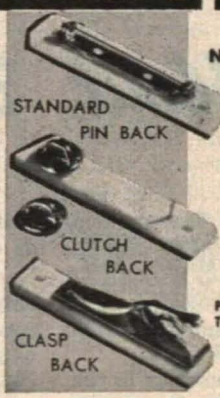


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discussed by Dr. Bogert in her text *Fundamentals of Chemistry*. She has attempted to keep experiments for the students on a simple level with more complicated procedures placed in the hands of the instructor. Each experiment is followed by questions worded so that they will bring out the main points to be observed. This questionnaire system of recording notes, the author feels, will be time-saving for both student and instructor since answers can be put into the manual, thus eliminating tedious copying and allowing for quicker checking. The completed manual provides a useful permanent record for the student.

**Mathematics of Drugs and Solutions** by Dorothy Walton Parry. 142 pages. The Macmillan Company of Canada, 70 Bond St., Toronto. Ed. 3. 1961.

"It fulfills the increasing need for a quick but thorough review of the simplest mathematical principles applicable to the administration of medications."

The author has attempted to standardize the approach to each problem, feeling that this saves time and energy

for both students and instructors. This is essentially an exercise book for the student to give as much practice as possible in mathematical problems related to medications. It is assumed that she understands the fundamentals of arithmetic. Consequently arithmetical explanation is kept to the minimum necessary to explain the practical application.

## - Other Publications -

**Nursing of Adults: A Plan for Teaching Care of Adults** by Dorothy W. Smith, R.N., Ed. D. Nursing Education Monograph Series. The Bureau of Publications, Teachers College, Columbia University. 64 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal 6. 1962. Price $2.00.

This publication is the first of a planned series under the egis of the Department of Nursing Education, Teachers College. The various presentations are to be representative of both faculty and student thought and study. They will constitute an organized contribution to nursing literature in line with the philosophy that graduate programs should encourage creative expression.

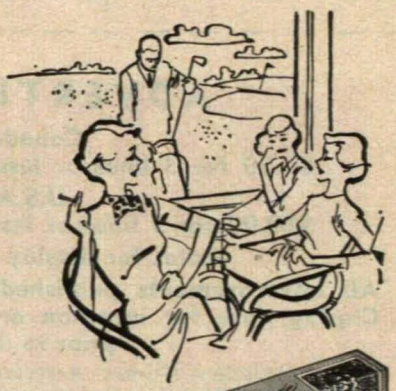
This particular monograph is based on a project carried out at Teachers College and is related specifically to a different approach to the teaching of medical-surgical nursing.

In the opening chapter the author compares traditional hospital nursing programs with university and collegiate programs in relation to the selection and organization of learning experiences for their educational value. She stresses the advantages of the collegiate program with its greater freedom to select on the basis of student need, to organize its program so as to provide a broader curriculum and improved sequence of learning experience.

Using this factor of greater freedom and prompted by her belief that the care of adults should be approached differently, the author concentrated on revision and reorganization of that area of the curriculum usually called "medical-surgical nursing." She discusses her subject under such topics as: The use of case material in helping students to face patient problems requiring a solution; the selection of health problems based on the age grouping of patients; adult development and developmental tasks. The final chapters discuss a teaching plan and the teacher's role.

An interesting, helpful booklet for teachers in any undergraduate nursing program.


Matinée



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**Registered Nurses** for active 20-bed hospital. Starting salary $290 with recognition for experience. 40-hr. wk., 28-day vacation after 1 year, accommodation in new separate residence $30. Apply to: Miss A. M. Morrison, Matron, Municipal Hospital, Bow Island, Alberta.

**Registered Nurses for General Duty** 37-bed hospital, salary to start $290 plus $15 increase each year to max. $335, board & room at $20 per mo., in separate nurses' residence. Apply in writing to: Matron, Municipal Hospital, Vulcan, Alberta.

**General Duty Nurses** for well-equipped 76-bed hospital in active town of 3,000. Salary $290 - $340 for Alberta registered; $280 - $330 for non Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta.

**General Duty Nurses** — starting salary $300 per mo., 40-hr. work wk., board, room & laundry available, if desired, at nominal rates. Civil Service holidays, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Department of Public Health, Calgary, Alberta.

**General Duty Nurses** (2) for 16-bed hospital, 100-mi N. E. of Calgary. 40-hr. wk., basic salary $290, room & board $35. Apply: Municipal Hospital, Elnora, Alberta.

**General Duty Nurse** (Immediately) for 32-bed Auxiliary Hospital. Starting salary $300 per mo., 40-hr. wk., sick leave benefits, good working conditions. For further particulars write to: P.O. Box 87, Rimbey, Alberta.

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**General Duty Nurses** for small active hospital. Salary $294 for unregistered Nurses in B.C. $312 registered, with yearly increments. Nurses' home available. For further particulars write: The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

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**General Duty Nurses** for active 30-bed hospital. RNABC policies & schedules in effect also Northern Allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia.

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**General Duty Nurses** for 200-bed General Hospital with School of Nursing. Salary range $309 to $374. Preplanned shift rotation, B.C. registration essential, 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

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**General Duty Nurses** for 31-bed hospital situated in the scenic Fraser Canyon. Salary: $300 non-registered; $315 B.C. registered. Nurses' home. M.S.A. Apply: Administrator, St. Bartholomew's Hospital, Lytton, British Columbia.

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**General Duty Nurses** for 40-bed hospital. Salary for B.C. registered nurses, $309-$374; non-registered B.C. nurses, $294. Nurses' residence available. Apply: Director of Nursing, Nicola Valley General Hospital, Merritt, British Columbia.

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**General Duty Nurses** for expansion program at modern hospital in very active community. Starting basic salary $309 for B.C. registered; $294 for non B.C. registered. Allowance made for qualifications & experience, RNABC personnel policies in effect, planned rotation, rooms available in new nurses' residence at $26 per mo. Apply to: Director of Nursing, Regional Hospital, Prince George, British Columbia.

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**Graduate Nurses** for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. Reg'd. Nurses $297 with regular increases; Unreg'd., $285. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

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**Graduate Nurses** for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $309 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

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**Graduate Nurse** for 31-bed hospital. Salary: B.C. registered $324, non B.C. registered $314 per mo. with annual increments. 40-hr. wk., 4-wk. vacation, 1-1/2 day sick leave per mo. Lodging $11 per mo. Travel refunded from Vancouver after 6 mo. Apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

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**Graduate Nurses** for 20-bed hospital, 35-mi. from Vancouver, on Coast. Salary & personnel practices in accord with RNABC. Bus & train transportation, accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

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**Operating Room & Obstetrical Nurses,** British Columbia registered, for modern 450-bed acute General Hospital, located on South Vancouver Island. Basic salary $309, credit for experience & postgraduate preparation, personnel policies in accordance with RNABC. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia.

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**Registered Nurses** (2) for 84-bed modern General Hospital. $315 per mo. with $5.00 increment every 6-mo., 40-hr. wk., 3-wk. vacation after one year, 8 statutory holidays & sick time cumulative to 14 days. Recognition for past experience. Good residence accommodation near hospital or in the neighborhood. Ste. Rose du Lac is situated on No. 4 Highway, 180-mi. northwest of Winnipeg, 30-mi. south of Dauphin. Growing community. For particulars, apply to: Director of Nursing, Ste. Rose General Hospital, Ste. Rose du Lac, Manitoba.

**Registered Nurses** for 165-bed hospital. Starting salary $285. Good personnel policies. Full orientation program. Apply: Nursing Service Officer, Victoria General Hospital, Winnipeg, Manitoba.

**Registered Nurses & Licensed Practical Nurses** (Immediately) for 700-bed modern General Hospital. Positions as **Head Nurse & General Duty** available on general medical & surgical wards, maternity, nursery, operating room, eye, ear, nose & throat, pediatrics & psychiatry. Salary in accordance with qualifications & experience. Must be eligible for Manitoba Registration. For further information write: Director of Nursing Service, General Hospital, St. Boniface, Manitoba.

## NOVA SCOTIA

**Registered Nurses** (2), one with operating room experience, **Grace Graduates (Maternity)** (3), **Certified Nursing Assistants** (3). Apply stating experience & qualifications to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

**General Duty Nurses** for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

**General Duty Nurses** for completely new, modern 165-bed hospital, full complement of services. Starting salary: $260 per mo. Good personnel policies. Apply to: Director of Nursing for particulars, Regional Hospital, Yarmouth, Nova Scotia.

## ONTARIO

**Operating Room Supervisor** with postgraduate course for active operating room in 86-bed hospital. Good salary and employee benefits. Apply to: Director of Nursing, General and Marine Hospital, Collingwood, Ontario.

**Operating Room Supervisor** with postgraduate training, for 145-bed active General Hospital in Ottawa Valley. Personnel policies include 5-day wk., 60 days cumulative sick leave, 3-wk. vacation, 8 statutory holidays, employer participation in pension plan. Send applications to: Miss E. I. Sheppard, Reg. N. Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

**Operating Room Supervisor** for 106-bed hospital with building program to 200-beds. Applications may be sent to: Acting Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

**Head Nurse & Assistant Head Nurse** (Applications are invited) Vacancies pending. Starting salary dependent upon qualifications & experience. Head Nurse $335 - $345; Assistant Head Nurse, $325 - $335, excellent personnel policies, residence accommodation available. Apply: Director of Nursing, The Queen Elizabeth Hospital, 130 Dunn Avenue, Toronto, Ontario.

**Registered Nurses** for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20 mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6 mo., sick & vacation time after 6 mo., sick time cumulative to 14 days, 37-1/2 hr. work wk., pension plan, living-in accommodation. Apply to: Director of Nursing, **Ajax & Pickering General Hospital, Ajax Ontario. Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

**Registered Nurses** for 34-bed hospital, min. salary $320, 3-wk. vacation with pay, sick leave after 6-mo. service. **Certified Nurses Assistants** salary $220, 2-wk. vacation with pay. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario.

**Registered Nurses** for immediate & future vacanices in this 42-bed hospital. Starting salary $320. Accommodation in new residence available. Pension plan & other benefits available. For full information apply to: Director of Nursing, New Liskeard & District Hospital, New Liskeard, Ontario.

**Registered Nurses** for 60-bed hospital, starting salary $300 gross per mo., good personnel policies. Apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

**Registered Nurses & Certified Nursing Assistants** for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

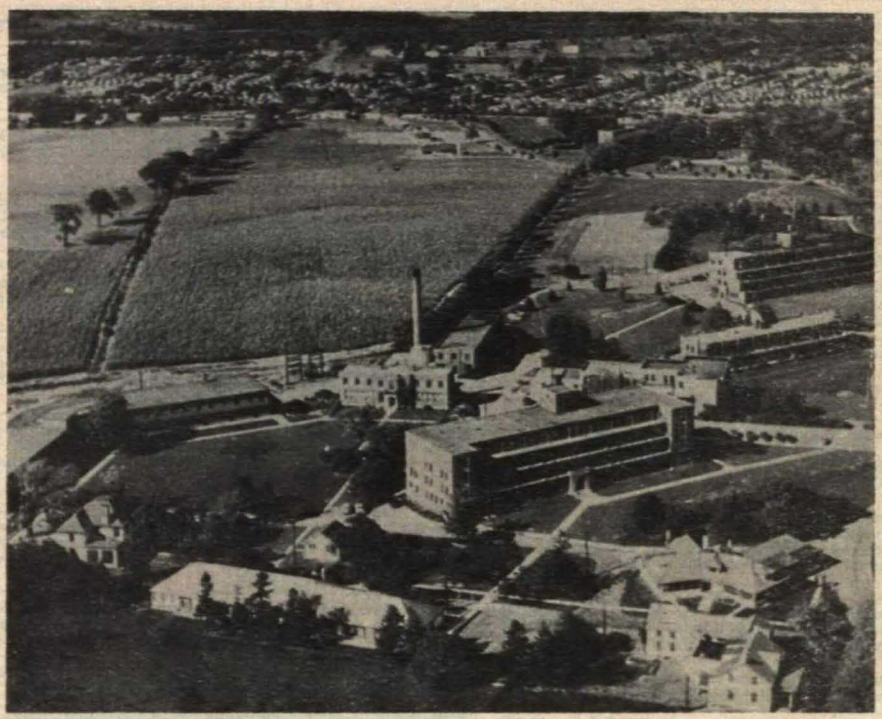
**Registered Nurses & Certified Nursing Assistants** for 160-bed accredited hospital. Starting salary $320 & $220 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Ontario hospital pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

**Registered Nurses & Certified Nursing Assistants** for 26-bed hospital. R. N. minimum salary $320, maximum $370, 28-day vacation after 1-yr. C.N.A. minimum salary $232, maximum $265, 2-wk. vacation after 1 yr., 3-wk. after 2 yr. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

**Registered Nurses for General Duty & Operating Room** in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $305 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

**Registered Nurses for General Duty** in modern 18-bed Private Hospital in iron mining town, 140 miles north of Sault Ste. Marie, Ontario. Starting salary $310 min. to $360 max., less $20 per mo. maintenance. Recognition for experience up to 3 years. Good accommodations & personnel policies. Transportation allowance after 6-mo. **Operating Room Nurse** starting salary $364 min. with postgraduate course to $414 max. with recognition for experience. Apply: Superintendent of Nurses, Lady Dunn Hospital, Wawa, Ontario.

**Registered Nurses** for General Floor Duty for 28-bed hospital in tourist & gold mining area. Basic salary: $315, 40-hr. wk. Please apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.



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**Registered or Graduate Nurses** for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario.

**Registered General Duty Nurses** (immediately) for new modern 35-bed hospital located in Almonte, 30-mi. from Ottawa. Good personnel policies. Apply to: The Director of Nursing Service, General Hospital, Almonte, Ontario.

**General Duty Nurses** for an accredited 66-bed hospital. Starting salary: $305. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

**General Duty Nurses** for modern 100-bed hospital. Registered start at $300 monthly, Graduates $250-$285; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. **Male Nurse,** graduate or registered also needed. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

**General Duty Nurses** for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

**General Duty Nurses Male & Female & Certified Nursing Assistants** (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

**General Duty Nurses & Certified Nursing Assistants** for new 50-bed hospital with modern equipment. 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario.

**General Duty Nurses, O.R. Nurses & Certified Nursing Assistants** for new 85-bed hospital with modern equipment, situated in a progressive town of 5,000 located 23-mi. from London, Ontario. Postgraduate education preferred, excellent personnel policies, salary commensurate with experience & qualifications, opportunity for advancement. Apply: Director of Nursing, Strathroy Middlesex General Hospital, Strathroy, Ontario.

**Operating Room Nurse** for 95-bed General Hospital with new O.R. facilities. Experience or postgraduate training desirable. Residence accommodation available. Apply to: Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

**General Duty Nurses** for small-sized hospital, good personnel policies and salary. Apply to: Superintendent, Kemptville District Hospital, Kemptville, Ontario.

**Public Health Nurses** (qualified) Salary $3,900 - $4,875, annual increment $195. Transportation provided, usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, Oshawa, Ontario.

**Public Health Nurses** (Qualified) for generalized nursing service. Salary range: $3,900 - $4,750 based on experience. Apply to: Dr. J. M. McGarry, M.O.H. St. Catharines-Lincoln County Health Unit, St. Catharines, Ontario.

**Nurses** with certificate in public health, required by Stormont, Dundas & Glengarry Health Unit in the Seaway Valley area. Generalized program. Minimum salary $3,700, annual increment, allowance for experience, 5-day wk. Employer-shared surgical group benefits, pension plan & Ontario Hospital Insurance, 3-wk. vacation, cumulative sick leave benefits, car allowance. Apply in writing giving qualifications & experience to: Miss Glenna French, Supervisor of Nurses, Box 1058, Cornwall, Ontario.

**Assistant Superintendent** (immediately) for small hospital. **Registered Nurse with operating room experience.** The usual hospital fringe benefits. Apply stating qualifications, experience & give references to: The Superintendent, Chesley & District Memorial Hospital, Chesley, Ontario.

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**Instructor** to be responsible for Nursing Assistant program. For full information, apply: Matron, King Edward VII Memorial Hospital, Bermuda.

**Registered Nurses for General Staff.** Full maintenance in new residence. Transportation allowance. For full particulars, apply: Matron, King Edward VII Memorial Hospital, Bermuda.

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**Registered Nurses:** We invite you to spend a winter in sunny California. Earn, learn, and enjoy life! Nurses coming together will be given same days off. Starting salary: $432 per mo. plus $25 bonus, evenings or nights. Experienced nurses who can do charge duty start at $455. Rooms in modern residence, $20 per mo. Openings on general medical-surgical wards, premature nursery, chest-medicine, neuro-surgery. Also need circulating nurses for O.R. Good in-service program, teaching hospital affiliated with 3 medical schools. Write for complete details to: Betty Hartwig, R.N., Box 1311, Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

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**Operating Room Supervisor** for modern, accredited 55-bed hospital. 40-hr. wk., 1-mo. vacation. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications to: Superintendent, Barrie Mecorial Hospital, Ormstown, Quebec.

**Assistant Head Nurses;** excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

**Registered Nurses** for 30-bed General Hospital, 50 mi. from centre of Montreal, excellent bus service. Starting salary $300 per mo., salary increased as recommended by ANPQ, 40-hr. wk. 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

**Registered Nurses & Certified Nursing Assistants** for modern 55-bed General Hospital, salary $300 per mo., 5 semi-annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $210, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

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**Operating Room Nurses,** neurosurgical experience preferred but must have at least one year's experience in general Operating Room technique. Apply: Director of Nursing, Montreal Neurological Institute, 3801 University Street, Montreal 2, Quebec.

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**SASKATCHEWAN**

**Registered Nurse for General Duty** for 24-bed hospital situated in S.E. Saskatchewan. Salary range $310 - $371, $15 per mo. yearly increase allowed for experience since 1956 up to the max. of $371. Annual bonus, 40-hr. wk., no split shift, residence, board & room $30 per mo., holidays etc. according to SRNA. 40 minutes from Moose Mountain Provincial Park. Apply: Redvers Union Hospital, Redvers, Saskatchewan.

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**U.S.A.**

**Director of Nursing Service** for modern, well-equipped 230-bed hospital, thoracic diseases, medical-surgical division, pediatrics, rehabilitation. Starting salary up to $613 per mo., depending upon qualifications. 11 holidays, 15 w.d. vacation annually. Apply: Medical Director, Tulare-Kings Counties Hospital, Springville, California.

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**Head Nurses** (Starting salary: $415), **Staff Nurses** (Starting salary: $395) for 100-bed hospital located in the pleasant San Joaquin Valley. $10 differential for evening & nights. Liberal fringe benefits. Modern nurses' residence on grounds at $10 per mo. Call collect or write to: Director of Nursing, Tulare County Hospital, Tulare, California.

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**Registered Nurses** for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

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**Registered Nurses** Career satisfaction, interest & professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational & cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $370 with automatic increases to $435 per mo., supervisory positions at increased rate. Special area & shift differentials paid. Excellent benefits including Blue Cross hospitalization & surgical coverage & liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

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**Registered Nurses** for 78-bed accredited hospital in friendly coastal city with pleasant climate. Do not rotate shifts. 40-hr. wk. **General Duty** — $365 basic salary. $20 differential for 3-11 or 11-7 shifts. **Experienced Operating Room Nurse.** Basic salary $375 with financial reimbursement for calls. **Obs. Nurses** — $375 basic salary, nurses' residence available at reasonable rates. Apply: Director of Nursing, General Hospital Eureka, California.

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**Registered Nurses** for 350-bed hospital, modern, all air conditioned new wing recently opened. Excellent salary with regular increments, differential for evenings & nights. Near beach & mountain resorts, nearby State College offers educational opportunities. For more information inquire: Director, Nursing Service, St. Mary's Hospital, 509 E. 10th Street, Long Beach, California.

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**Registered Nurses, Staff Nurses for permanent positions,** various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

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**Registered Nurses** (Immediate openings in California). Expansion of our General Hospital has enabled us to offer excellent opportunities in all occupational specialties. Starting salaries: General Duty $390 per mo. days, $415 per mo. P.M.'s and Nights, $10 differential per mo. for psychiatry. Operating Room $415 per mo. days, $440 per mo. P.M.'s. Liberal employment benefits. The best in working conditions. Write: Personnel Dept., Sutter Community Hospitals, 2820 "L" Street, Sacramento, California.

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**Registered Nurses** for private 258-bed hospital for men, women & children. Staff Nurse salaries from $355-$435, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

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**Registered Nurses** General Duty for 230-bed approved teaching hospital, resort city. Starting salary $350 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

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**Registered Nurses** for accredited 230-bed hospital thoracic diseases, medical-surgical division, pediatrics, rehabilitation. **Supervising Nurses** $458/$530, start $481 if experienced; **Head Nurses** $415/$481, start $436 if experienced; **Staff Nurses** $376/$415; $10 afternoon & night shift differential. Living accommodations for single woman. 11 holidays, 15 w.d. vacation annually. Beautiful Sierra foothill location. Apply: Director of Nurses, Tulare-Kings Counties Hospital, Springville, California.

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**Registered Nurses.** Positions open in beautiful southern California hospital. Excellent opportunities. California registration available & required. Please apply to: Director of Nursing, Little Company of Mary Hospital Torrance, California.

---

**Attention! General Duty Nurses** 300-bed fully accredited County Hospital located 2-hr. drive from San Francisco, ocean beaches, & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., pd. vacation, pd. holidays, pd. sick leave, retirement plan, social security & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Effective 11-1-62 starting salary $395 per mo., plus shift & service differentials. Must be eligible for California registration. Write: Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

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**Staff Nurses** for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

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**Staff Nurses** for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

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**Operating Room Nurses** — Combine business with pleasure — Live & work in California. Starting salary: $415 per mo. days, $440 P.M.'s. Top benefits. Excellent working conditions. Write: Personnel Dept., Sutter Community Hospitals, 2820 "L" Street, Sacramento, California.

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**Nurses** for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California.

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**General Duty Nurses** for various departments including surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases & fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado.

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**Registered Nurses, Licenced Practical Nurses** for 250-bed hospital. Excellent benefits including retirement plan. Ocean bathing & housing accommodation available. Apply: Director of Nursing Service, St. Francis Hospital, Allison Island, Miami Beach, Florida.

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**Registered Nurses** for 200-bed General Hospital located in beautiful suburban residential area on Lake Michigan, 30 min. from Chicago. Base salary $380, differential of $20 for nights, $30 for evenings. Live in modern nurses' bungalows adjacent to hospital and enjoy social, cultural and educational advantages of Chicago. Recent completion of new building creates opportunities in all clinical services, liberal personnel benefits include free retirement program. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

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**Graduate Nurses (Professional)** Choose a career at Chicago's renowned medical-teaching center. Various staff & special assignments available to provide a work setting compatible with your interests & experience. Starting salary to $420 per mo., plus $40 evening differential & premiums for special assignments. Fringe benefits include vacation to 4-wk. per year, 8 paid holidays, cumulative sick leave, Blue Cross & pension plan, private rooms in modern residence building. Your inquiries are invited: Director, Nursing Service, Dept. C.J.N., Mount Sinai Hospital, 2750 W. 15th Place, Chicago 8, Illinois.

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**Staff Nurses & Licensed Practical Nurses** (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s.; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth Hewitt, R.N., Director of Nurses, Chelsea Memorial Hospital, Chelsea, Mass.

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**Staff Nurses** 380-bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks., 5 yrs. — 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611.

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**COURSES** FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING, OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

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**Graduate Nurses** for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio.

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**Staff Nurses** for large modern tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $375 days, $407 evenings, $396 nights, with semi-annual increments, 5-day work wk., paid vacation & 6 holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn & earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

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**Registered Nurse** (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

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**Staff Nurses** (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas.

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**Male Psychiatric Nurse** to supervise a unique Psychiatric Research Unit near Houston, Unit is operated by Baylor University College of Medicine & Houston State Psychiatric Institute. Starting salary $5,000 per annum with house, utilities & servant. Full time staff in Psychiatry & Psychology. Research is mostly Psychopharmacological at present but embraces all aspects of Penal Psychiatry. Opportunity for close association with Houston State Psychiatric Institute (Miss Patricia Collum, Director of Nurses). Apply: Director, 1300 Moursund Avenue, Houston, Texas.

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**General Duty Nurses** (Must qualify Washington State Registration) for 56-bed General Hospital beginning expansion program to 80 beds. Starting salary $355 plus shift differentials evenings & nights. Culture, sports & other areas of "off-duty" interest at your door-step. Apply: Director of Nurses, Overlake Memorial Hospital, Bellevue, Washington.

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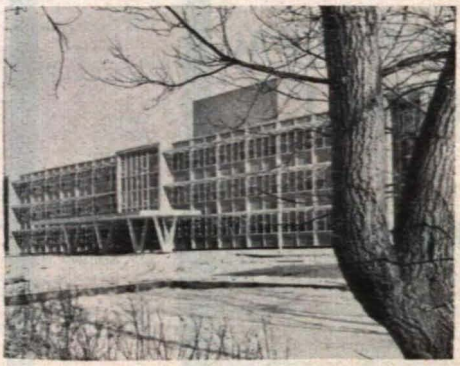
## PEACE RIVER MUNICIPAL HOSPITAL



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Appointments for the 1962 summer vacation program are now available at $297 or $311 per month with approved experience.

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invites applications for the position of

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**An applicant must be a registered nurse possessing a baccalaureate degree and experience in nursing education, nursing service, or both. Duties include the organization and management of educational programs developed by the Nursing Education and Nursing Service Committees, and the secretarial work of other boards and committees responsible for the educational functions of the Association.**

**Salary range: $4,800 - $6,000**

***Application should be made by letter, stating qualifications, experience and salary expected, and should be adressed to :***

**MISS A. I. MALONEY, President**

**Manitoba Association of Registered Nurses • 247 Balmoral Street • Winnipeg 1, Manitoba**

# NURSING CONSULTANT

***Required for***

**SANATORIUM BOARD OF MANITOBA**

operating 5 hospitals for Rehabilitation and Physical Medicine, Extended Treatment, and Tuberculosis, respectively.

Responsible for:

1: Nursing Services and quality of nursing care.

2: Development of in-service education programs.

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Salary according to experience and qualifications.

Appointment immediately.

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## REGISTERED NURSES

and

## NURSING ASSISTANTS

**required for modern 400-bed hospital.**

Good salaries and personnel policies. New 13 storey staff apartment for nurses including married couples — one block from hospital — furnished and unfurnished suites (including broadloom and drapes) — rates reasonable — convenient to downtown.

*Apply :*

DIRECTOR OF NURSING
NEW MOUNT SINAI HOSPITAL
550 UNIVERSITY AVENUE
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## CITY OF HAMILTON

*requires a*

**PUBLIC HEALTH NURSE**

Must be a Registered Nurse with a public health certificate

**5 day — 36¼ hour week**
**Minimum salary: $3,858**
**Maximum salary: $4,588**

Starting salary commensurate with previous experience

Top fringe benefits including pension, sick pay, group insurance, vacations, statutory holidays, hospital and medical plan

*Apply to:*

DIRECTOR OF PERSONNEL
CITY HALL, HAMILTON, ONTARIO

## DIRECTOR OF NURSING

For modern, accredited 100-bed hospital, soon to enter the planning stage of expansion to 200 beds.

Salary commensurate with qualifications and experience. Excellent personnel policies.

*Apply with full particulars to :*

ADMINISTRATOR,
NORTH BAY CIVIC HOSPITAL,
NORTH BAY, ONTARIO.

## PUBLIC HEALTH NURSES

**Required by the City of Toronto, Department of Public Health.**

Qualified Public Health Nurses for generalized Public Health Nursing Service. Salary range $4,108—$4,647. Starting salary based on experience. Annual increments, vacation, shared hospital and medical insurance, sick pay and pension plan.

*Apply : Personnel Department,*

ROOM 320, CITY HALL,
TORONTO 1, ONTARIO.

## NURSES WANTED

**GENERAL DUTY NURSES**

for a modern 75-bed accredited hospital situated in the beautiful Parkland District of Saskatchewan. Salary: $290-$330 per month. A 5 day 40 hour week with no split shifts. Accommodation with meals are available at a very reasonable price on the hospital grounds.

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THE DIRECTOR OF NURSING SERVICES
CANORA UNION HOSPITAL
CANORA, SASK.

### MISCELLANEOUS

**Registered Nurses** for busy 44-bed active treatment hospital. Salary: $325 per mo. with bi-yearly increments. Excellent accommodation in recently opened nurses' residence. Medical and Hospitalization Group Plans. Liberal holiday and sick schedule. Apply: Holy Cross Hospital, Box 339, Spirit River, Alberta.

**Graduate Nurses** (immediately) for The Drumheller Municipal Hospital. Drumheller is rapidly becoming a very busy trading centre as well as becoming the mecca for tourists. Easy access is offered to the modern swimming pool and golf course. Many enjoy collecting fossils. Apply to the undersigned for an opportunity to serve under pleasant and stimulating surroundings. Miss M. Hawkes, R.N., Director of Nursing, Drumheller, Alberta.

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**General Duty Nurses** (2). Starting salary: $309, personnel policies in accordance with provincial agreement. Health plan and retirement plan in operation. Comfortable nurses 'residence, full maintenance $55. Situated 80 mi. upcoast from Vancouver with daily bus and plane connections. Apply to: The Director of Nursing, General Hospital, Powell River, British Columbia.

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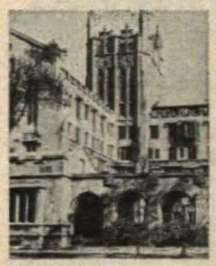
# COME TO CHICAGO



*and the great*
*University of Chicago Hospitals*

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Participate in campus and community activities . . . continue to learn at greatly reduced tuition . . . live in University-owned housing near the lake.

SALARIES: $410–$560
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# MONTREAL CHILDREN'S HOSPITAL

*invites applications from*

**GRADUATE NURSES**

and

**CERTIFIED NURSING ASSISTANTS**

to fill vacancies on medical and surgical wards as well as specialty departments as Premature Surgery, Neuro-Surgery - Metabolism - Psychiatry - Out Patient Department - Operating Room and Intensive Care. Salaries in accordance with ANPQ recommendation, differential for Post-basic preparation. Good personnel policies. In-service program.

*Write:*

DIRECTOR OF NURSING, MONTREAL CHILDREN'S HOSPITAL
2300 TUPPER STREET, MONTREAL 25, QUEBEC

## PUBLIC HEALTH NURSES

**REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE**

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $356-$440 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION No. 62:57

## HEAD NURSE OPERATING ROOM

Postgraduate certificate required for charge position in this 110-bed hospital in Northwestern British Columbia.
RNABC personnel and salary policies in effect plus $15 per month.
Comfortable modern nurses' residence available - Full maintenance $50 per month

*For further information apply to:*

DIRECTOR OF NURSING, PRINCE RUPERT GENERAL HOSPITAL
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Applications are invited for the position of

## ASSOCIATE DIRECTOR OF NURSING SERVICE

for

**ROYAL INLAND HOSPITAL, KAMLOOPS, B.C.**

204-bed fully accredited General Hospital with School of Nursing. Large expansion program approved. Salary commensurate with preparation and experience. Position available October, 1962.

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# REQUIRED IMMEDIATELY

**THREE INSTRUCTORS OF NURSING**

**School of Nursing — Brandon General Hospital**

STUDENT ENROLLMENT 60

HOSPITAL BEDS 220

Post-basic preparation in
Teaching and Supervision required,
experience desired.

Recognition given for preparation and experience

*For further particulars apply to:*

**PERSONNEL OFFICER**
**BRANDON GENERAL HOSPITAL**
**BRANDON, MANITOBA**

# THE GENERAL HOSPITAL OF PORT ARTHUR

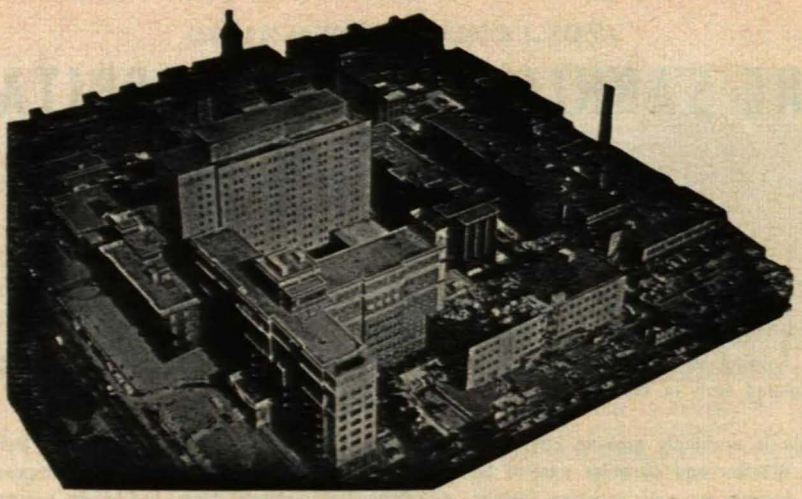
*Invites applications for the positions of*

**ASSISTANT DIRECTOR OF NURSING EDUCATION**

SALARIES COMMENSURATE WITH
QUALIFICATIONS AND EXPERIENCE

*Apply to:*

**DIRECTOR OF NURSING**
**GENERAL HOSPITAL OF PORT ARTHUR**
**PORT ARTHUR, ONTARIO**



# TORONTO GENERAL HOSPITAL

*Requires*

**REGISTERED NURSES and CERTIFIED NURSING ASSISTANTS**

**for Medical and Surgical Services**

**including newly opened Neurosurgical and Cardiovascular Units**

**REWARDING EXPERIENCE — EXCELLENT PERSONNEL POLICIES**

***For information write to:***

**DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL, 101 COLLEGE STREET, TORONTO 2, ONT.**

# GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $320 monthly with annual increments for 3 years to $350.

Until registration in Ontario is established — $295.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, cumulative to 18 days. Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

***Apply:***

**DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO**

# THE SARNIA GENERAL HOSPITAL

*offers excellent opportunities for*

**REGISTERED NURSES**

*and*

**CERTIFIED NURSING ASSISTANTS**

The hospital is modern, fully approved (JACH) with expansion now in progress, to be completed early in 1963.

Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

Excellent benefits include a 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

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**PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO**

# JEWISH GENERAL HOSPITAL MONTREAL QUE.

**NURSING OPPORTUNITIES**

In this modern 400-bed non sectarian hospital in Administration, Teaching, Staff Nursing. Certified Nursing Assistants also required. Openings in Psychiatry, Pediatrics, Obstetrics and Medicine and Surgery. Excellent personnel policies. Bursaries for post-basic courses in Teaching and Administration

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OUR HOSPITAL IS ENJOYING AN EXCITING DEVELOPMENT WHICH IS CONSISTENT WITH THE ACTIVITIES AND ATTITUDES OF OUR CITY AND THE ENTIRE PACIFIC NORTHWEST. HERE IS A CHANCE TO BETTER YOURSELF PROFESSIONALLY AND ECONOMICALLY IN A COSMOPOLIAN AREA WITH AN IDEAL WORKING CLIMATE. PUGET SOUND, OUR LAKES AND MOUNTAINS OFFER UNSURPASSED RECREATIONAL FACILITIES.

*Swedish Hospital—Seattle's largest and busiest hospital—now expanding again, offers . . .*

- **Highest standards of nursing care**
- **Top pay with specialty premiums ($355 - $400)**
- **Liberal fringe benefits**
- **Educational opportunities**

*For details, write . . .*
**Director of Nursing Service**

## SWEDISH HOSPITAL

**1212 Columbia, Seattle 4, Washington**

# NURSES, REGISTERED

**250-bed General Acute Hospital, Centrally located in SAN FRANCISCO, CALIFORNIA**

**IMMEDIATE day, evening and night positions available for nurses in:**

**SURGERY, CARDIAC AND INTENSIVE CARE, GENERAL STAFF DUTY**

**Qualified applicants guaranteed positions for visa purposes**

**SALARY RANGE** from $365-$435 plus $36.50 P.M. shift (3-11:30 P.M.) and specialty differentials, medical benefits and liberal holiday and vacation benefits.

**GRADUATE** medical resident program with University of California Medical School in General Surgical, Neurological, Ortho, and Plastic Surgery.

***For further information, please write to:***

**MISS LOIS JAHN, DIRECTOR OF NURSING, FRANKLIN HOSPITAL,**

**14th and Noe Sts., San Francisco, Calif.**

## WOODSTOCK GENERAL HOSPITAL

**WOODSTOCK, ONTARIO**

*requires*

**MEDICAL CLINICAL TEACHER**

**Preferably with B.Sc.N. degree and experience.**
**Position will be open on January 1st, 1963.**
**Salary commensurate with qualifications and experience.**

*Apply to:*

**DIRECTOR OF NURSING**
**WOODSTOCK GENERAL HOSPITAL, WOODSTOCK, ONTARIO.**

## ASSISTANT DIRECTOR - NURSING SERVICES

Applications are invited for the position of

**ASSISTANT DIRECTOR,**

Nursing Services in University Hospital, Saskatoon, Saskatchewan.
For a 550-bed hospital situated on the campus.
University preparation desirable.

*Apply to:*

**DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,**
**SASKATOON, SASKATCHEWAN.**

## OPERATING ROOM NURSE

- **For 40-bed hospital located in a progressive community.**
- **Good salary and personnel benefits.**

*Apply : Giving age, qualifications, experience and salary expected.*

**ESPANOLA GENERAL HOSPITAL**
**ESPANOLA, ONTARIO.**

## REHABILITATION INSTITUTE OF MONTREAL

**110-bed new hospital, opening 3rd ward early fall.**

*Positions available for:*

**BILINGUAL GENERAL DUTY NURSES**
**BILINGUAL CERTIFIED NURSING ASSISTANTS**

**Preference given to nurses having experience with paraplegics and hemiplegics.**
**Excellent working conditions: pension plan, group insurance and other advantages.**

*For more information contact:*

**DIRECTOR OF NURSING**
**REHABILITATION INSTITUTE OF MONTREAL**
**6300 DARLINGTON AVENUE, MONTREAL, P.Q.**

## MRS. COWARD'S TRAINED NURSES' INSTITUTE

62 ST. GEORGE'S SQUARE, LONDON, S.W.1.

*Founded 1904*

Vacancies are available for selected State Registered Nurses who desire to undertake private nursing on the basis of fees recommended by the Royal College of Nursing.

The Institute operates for the benefit of nurses, not being a profit-making concern, and comfortable board residence facilities are available at its premises at moderate prices. Full particulars may be obtained on application to the Sister-in-Charge at the above address.

*Nurses should, before leaving, apply to:*

*(a) An office of the British Information Service, or a British Passport or Trade Commission office for a United Kingdom Employment Voucher, pursuant to the Commonwealth Immigrant Act 1962.*

*(b) The Registrar for registration with the GENERAL NURSING COUNCIL FOR ENGLAND and WALES (23 Portland Place, London, W.1.)*

## THE ROOSEVELT HOSPITAL

**in New York City offers**

## Canadian Registered Nurses

- A 450-bed teaching hospital in the heart of New York City.
- Full tuition assistance for 4 credit hours.
- Base salary $380 per mo. - $50 bonus for evenings and nights.
- 4 Weeks paid vacation, liberal sick leave and hospitalization.
- Housing-at-cost adjacent to the hospital.

*For further information please write Director of Nursing Service*

**THE ROOSEVELT HOSPITAL**

**Dept. CN, 428 West 59 St., New York City 19, N.Y.**

## REGISTERED NURSES

*required*

For new modern 16-bed hospital in northern Alberta. Good accommodations and communications. Progressive farming and industrial area served by our hospital. Fare paid from any point in Canada. Salary commensurate with AARN schedule and experience. If interested, please write, or phone, or wire collect for further details. If writing, please state date available, salary expected, and experience.

*Apply:*

**MANNING MUNICIPAL HOSPITAL**
**2nd AVENUE NORTH, MANNING, ALBERTA**

## REGISTERED NURSES
## NURSING ASSISTANTS

Required for all departments in new 163-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week

*Apply stating age, qualifications to:*

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**OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL,**
**OAKVILLE, ONTARIO**

# REGINA GENERAL HOSPITAL

**Regina, Saskatchewan**

*Invites applications for the position of*

**DIRECTOR of NURSING and PRINCIPAL OF THE SCHOOL OF NURSING**

800-bed fully accredited general hospital, with large School of Nursing. Expansion and replacement program in planning stage. Organization provides Associate Directors of Nursing Service and Nursing Education. Remuneration as comparable with that paid well qualified persons with similar positions in Canada. Benefits include Pension Plan, Group Life Insurance, sick leave, four weeks' vacation, with living-in accommodation, if desired.

*Enquiries and applications to be forwarded to:*

**MR. C. E. BARTON,**
Executive Director

# RECENT GRADUATE OPPORTUNITIES IN NURSING

Staff positions will be available for Registered Nurses with special interest in rehabilitation and medical nursing. Those showing aptitude will have an excellent opportunity for early advancement to fill newly created posts which command the increases in remuneration as recommended by the Registered Nurses' Association of Ontario.

Starting monthly rate $305 - 325. Private residence accommodation with adjoining bath available. Full maintenance $40 monthly. Good location. Transportation advanced if requested.

Participation in clinical conferences, and in-service education program encouraged.

*For information contact The Director of Nursing,*

**The Queen Elizabeth Hospital,**
**130 Dunn Ave.,**
**TORONTO 3, Ont.**

# REGISTERED NURSES

and

# CERTIFIED NURSING ASSISTANTS

for

375-bed, fully accredited General Hospital. Registered Nurses salary $300 - $340 per month. Certified Nursing Assistants $200 - $230 per month.

*For further information write:*

**DIRECTOR OF NURSING SERVICE**
**METROPOLITAN GENERAL HOSPITAL**
**WINDSOR, ONTARIO**

# ASSISTANT DIRECTOR OF NURSING SERVICE

**Urgently Required**

For modern 100-bed General Hospital in St. Lawrence Seaway community.

Applicants must have wide nursing experience and preferably, university preparation in nursing administration. Good personnel policies, salary commensurate with experience and qualifications.

*Apply in writing to:*

**The Director of Nursing**
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**WINCHESTER, ONTARIO.**

## THE MONTREAL GENERAL HOSPITAL

offers an interesting variety of experience
to Staff Nurses in a modern 750-bed hospital

*For further information apply to:*

**DIRECTOR OF NURSING, THE MONTREAL GENERAL HOSPITAL**
**1650 Cedar Avenue, Montreal 25, Que.**

## THE SCHOOL OF NURSING

**BROCKVILLE GENERAL HOSPITAL, BROCKVILLE, ONT.**

Invites applications for — Instructor
Requirements: University preparation in Nursing Education
Salary differential for degree

*Apply to:*

**DIRECTOR OF NURSING**

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**HAMILTON, ONTARIO**

Opening large modern addition - Autumn, 1962 - 900-bed capacity

Nursing facilities, both attractive and efficient, await the professional graduate nurse. A Six-Million Dollar expansion provides for a new air-conditioned building, with modern Admitting Wing, Emergency Unit, Operating and Recovery Rooms, Intensive Care Unit, Patient Rooms, Wards and Play Areas, enlarged Laboratories and a New Dining-Room for the personnel. Orientation and Active In-Service program. Clinical areas for Student Nurses and Medical Interns - The City of Hamilton is within easy access to the Niagara Peninsula and U.S.A.

Positions available in all clinical areas

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## OPERATING ROOM NURSES

For 163-bed active hospital, located in a progressive community between Toronto and Hamilton. Postgraduate training or experience essential. Good salary and personnel policies.

*Apply giving age, qualifications and experience to:*

**DIRECTOR OF NURSING**
**OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL**
**OAKVILLE, ONTARIO**

**CORNER BROOK**

## Graduate Nurses

are invited to enquire re:

Employment opportunities in Canada's newest Province.

- Fully-accredited 110-bed hospital,
- Progressive community of 27,000
- Magnificent scenery and recreational facilities
- Transportation advanced
- Residence available

*Enquire to:*

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**CORNER BROOK, NEWFOUNDLAND**

## HAMILTON CIVIC HOSPITALS

**GENERAL STAFF NURSES**

*required for*

INTENSIVE CARE UNIT
SURGERY, MEDICINE,
EMERGENCY DEPT.,
AND OPERATING ROOMS

*For personnel policies and further information apply to:*

**DIRECTOR OF NURSING**
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**HAMILTON, ONTARIO**

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General Staff Nurse positions available in General Operating Rooms (general surgical, cardiac, neuro-surgical, plastic, orthopedic, ear, nose and throat, and urology). Positions also in Gynecological and Ophthalmological operating rooms. Salary commensurate with experience, excellent additional benefits including refund of tuition up to six points per semester.

*For further information write to:*

**DIRECTOR, NURSING SERVICE**
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**MEDICAL CENTER**
**Ann Arbor, Michigan**

Offers challenging positions to qualified Registered Nurses

1000-bed hospital - All Clinical Services

Good salaries - $375 to $415 and generous fringe benefits

*For further information write:*

**ROBERT J. GREENOUGH**
**DEPT. F - UNIVERSITY HOSPITAL**
**UNIVERSITY OF MICHIGAN**
**MEDICAL CENTER**
**ANN ARBOR, MICHIGAN**

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Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and education. Write for more information and the booklet "New Horizons in Nursing," to:

**DIRECTOR OF NURSING,**
**UNIVERSITY HOSPITALS OF CLEVELAND,**
**University Circle, Cleveland 6, Ohio**

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If you desire to practise your profession in a modern and scientific hospital, that has 21 specialties and 1,050 beds, join the nursing staff of

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Generous salaries, according to qualifications, with periodic increases. Differential for evening and night duty, 10 statutory holidays. Vacation based on date of employment. Pension plan. In-service education program. Recreational center

*For information, write to:*

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**HOPITAL NOTRE-DAME, 1560 est, rue Sherbrooke, Montréal 24**

# THE PETERBOROUGH CIVIC HOSPITAL
**REQUIRES**

Head Nurse for Pediatric Department

General Duty Staff Nurses

*For further information write:*

**THE DIRECTOR OF NURSING**
**PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO**

# SUBURBAN TORONTO
## Graduate Nurses & Certified Nursing Assistants

Are invited to enquire re: employment opportunities in a well-staffed 125-bed hospital in suburban west Toronto now expanding to 350 beds. General Staff Nurses salary range: $305-$355 per month. Certified Nursing Assistants $225-$255 per month, 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

**DIRECTOR OF NURSING - HUMBER MEMORIAL HOSPITAL**
**200 Church Street, Weston, Toronto 15, Ontario - CH. 4-5551**

## NURSING SUPERVISOR
and a
## REGISTERED NURSE
for

110-bed "HOME FOR THE AGED" with 50-bed bed-care wing. Located on Grand River, Niagara Peninsula within 1 hour's travel to Hamilton, Niagara Falls and Buffalo, N.Y. Modern staff quarters optional

*For full particulars apply Superintendent, Stating Qualifications, Experience and Remuneration.*

GRANDVIEW LODGE, DUNNVILLE, ONT.

## REGISTERED NURSES
Operating Room Nurse
and
## CERTIFIED NURSING ASSISTANTS
*required for*

82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.
*For salary rates and personnel policies*

*apply to :*

DIRECTOR OF NURSING
HALDIMAND WAR MEMORIAL HOSPITAL
DUNNVILLE, ONTARIO

## OTTAWA CIVIC HOSPITAL
requires
## GENERAL STAFF NURSES
for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL AND
PSYCHIATRIC
} DEPARTMENTS

*Apply*

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Assistant Director and Administrator of the Department of Nursing

## MANITOBA REHABILITATION HOSPITAL
*Requires*
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Interesting and challenging work in the rehabilitation nursing field.

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MANITOBA REHABILITATION HOSPITAL
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BURLINGTON, ONTARIO

Ideally located
- on the north shore of Lake Ontario
- six miles to Hamilton
- thirty miles to Toronto
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- excellent access to New York State

Friendly hospital and community
- hospital capacity 228 beds
- services: medical, surgical, pediatrics, obstetrics
- staff association
- active recreational program.

*ENQUIRIES ARE INVITED*
*WRITE TO THE*
DIRECTOR OF NURSING

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## THE McKELLAR GENERAL HOSPITAL

needs progressive nurses and will prepay costs of transportation for those nurses who will remain on staff for one year. Personnel policies are good — the people are friendly.

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FORT WILLIAM, ONTARIO

## REGISTERED NURSES
and
## CERTIFIED NURSING ASSISTANTS

are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

*Enquire:*

DIRECTOR OF NURSING
ROSS MEMORIAL HOSPITAL
Lindsay, Ontario

## REGISTERED NURSES as Floor Supervisors

in Geriatric Institution near New York City. Starting salary $4,500 per annum, 37½-hour week plus fringe benefits totalling $700, includes 4 weeks paid vacation, 12 days paid sick leave, 7 paid holidays, Xmas bonus of 1 week's salary. Additional Medical and Life Insurance Policy free of charge. No deduction for meals, residential accommodation $200 year.

*Write:*

EXECUTIVE DIRECTOR,
DAUGHTERS OF MIRIAM,
CLIFTON, NEW JERSEY

Applications are invited for the position of

## ASSISTANT DIRECTOR OF NURSING SERVICE

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONTARIO.

Salary commensurate with qualifications and experience.

*Apply to:*

DIRECTOR OF NURSING, McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONTARIO.

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## THE CENTRAL REGISTRY OF GRADUATE NURSES TORONTO

Furnish Nurses
at any hour
DAY or NIGHT

**Telephone: 483-4306**

460 Eglinton Avenue East, Suites 301-302
Toronto 12, Ontario
JEAN C. BROWN, REG.N.

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## GENERAL STAFF NURSES

*Required for*

CLEARWATER LAKE HOSPITAL
THE PAS, MANITOBA

Interesting positions immediately available for hospital of 150 beds for tuberculosis (Indians and Eskimos) and extended treatment patients. Initial salary $310 per month.

*Apply to:*

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SANATORIUM BOARD OF MANITOBA
800 SHERBROOK STREET
WINNIPEG 2, MANITOBA

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## STAFF NURSES

REQUIRED IMMEDIATELY

for modern, fully accredited 162-bed hospital, in the following departments:

SURGICAL, MEDICAL and OPERATING ROOM.

A large new construction and renovation program is well in progress which will add 40 beds, and enlarge and modernize the service departments. Salaries according to experience. Excellent personnel policies. O.H.A. Pension Plan. Stratford is a delightful city of 20,000 within easy reach of larger centers.

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Breaking in to earthlings,
Hungry, lonely, fearful,
Appealing little birthlings !
Crying, crying, crying . . .
While nurses clock-watch, sighing,
Waiting on the Time.
Nothing do they heed,
But the time to bathe and feed.
Nothing near, nothing dear,
Not a Baby do they hear.
Just row on row of species homo,
To diaper in a marathon
And practice their procedures on.
Keep them hungry !
Keep them lonely !
Don't you touch them . . .
Let them cry . . .
Why ? Why ? Why ?
Such a breaking in to life !
Building up for future strife ?
Now I'm off, I'm out, I'm done.
Thank God I'm not the only one
That sees each little Person there
Needing love and special care.
Not a schedule and a slap
To help them bridge the fearsome gap
From mother's soft and closed-in womb
To noisy overcrowded room.
Morsels of humanity, atoms of God,
Breaking into earthlings,
Hungry, lonely, fearful,
Appealing little birthlings !

—Reba Riddle, R.N.

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| 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 |

NAME .....

ADDRESS .....

CITY ..... Zone ..... Prov. .....